AMENDED IN SENATE JULY 2, 2003

AMENDED IN ASSEMBLY APRIL 21, 2003

CALIFORNIA LEGISLATURE—2003–04 REGULAR SESSION

ASSEMBLY BILL No. 1579

Introduced by Assembly Members Cogdill ~~and Richman~~, *Aghazarian, Benoit, Bogh, Daucher, Keene, Maddox, McCarthy, Richman, and Wyland*

February 21, 2003

~~An act to amend Section 139.3 of the Labor~~ *An act to amend Sections 139.3, 139.5, 3201.5, 3202, 3208, 3208.1, 3208.3, 3600, 4600, 4603.2, 4637, 4639, 4642, 4646, 5307.1, 5410, and 5502 of, to add Sections 139.15, 139.7, 139.71, 139.72, 139.73, 139.74, 3201.6, 3821, 4062.7, 4453.1, 4600.31, 4600.37, 4635.15, 5307.27, and 5705.1 to, to repeal Sections 3201.7, 5307.21, and 5814.5 of, and to repeal and add Sections 4600.1 and 5814 of, the Labor* Code, relating to workers' compensation.

LEGISLATIVE COUNSEL'S DIGEST

AB 1579, as amended, Cogdill. Workers' compensation~~: physician referral: outpatient surgery~~.

~~Existing law provides that, to the extent these services are paid pursuant to the workers' compensation law, it is unlawful for a physician to refer a person for clinical laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services whether for treatment or medical-legal purposes if the physician or his or her immediate family has a financial interest with the~~

~~person or in the entity that receives the referral. Violation of this provision is a misdemeanor.~~

~~This bill would extend the application of this provision to outpatient surgery goods or services. By expanding the definition of a crime, this bill would impose a state-mandated local program.~~

~~The~~

(1) Existing law establishes a workers' compensation system to compensate an employee for injuries sustained in the course of his or her employment.

Existing law provides that, to the extent these services are paid pursuant to the workers' compensation law, it is unlawful for a physician to refer a person for clinical laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services whether for treatment or medical-legal purposes if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral. Violation of this provision is a misdemeanor.

This bill would extend the application of this provision to outpatient surgery goods or services. By expanding the definition of a crime, this bill would impose a state-mandated local program.

(2) Existing workers' compensation law provides for the treatment of injured workers by physicians. Existing law requires the Industrial Medical Council, among other things, to counsel and assist the Administrative Director of the Division of Workers' Compensation and suggest standards for improving care furnished to injured employees. Existing law requires the Industrial Medical Council to appoint physicians as qualified medical evaluators in each of the respective specialties as required for the evaluation of medical-legal issues.

This bill would require every physician who treats and evaluates injured workers, on and after January 1, 2006, to be certified by the Industrial Medical Council as a Qualified Workers' Compensation Physician (QWCP). It would exempt physicians who are qualified medical evaluators from the QWCP certification requirement, and would authorize the council to waive this requirement under certain circumstances. The bill would require the council, on or before January 1, 2005, to establish a QWCP certification program containing specified criteria.

The bill would also require the administrative director, on or before January 1, 2005, to contract, to the extent permitted by state law, with

a public or private university or policy institute in the state to develop physician utilization management, quality of care, billing, and outcome measurement data, and to publish a report, on or before July 1, 2006, and annually thereafter, that includes this data.

(3) Existing law establishes permanent disability ratings for injured workers.

This bill would require the administrative director, by January 1, 2005, to establish a mandatory annual training program for persons in the Disability Evaluation Unit within the Division of Workers' Compensation of the Department of Industrial Relations who determine permanent disability ratings for injured workers.

(4) Under existing law, workers' compensation claims are processed by the insurance companies that provide the insurance coverage to the employer.

This bill would require the administrative director, by January 1, 2005, to establish a mandatory annual insurance claim administrator training program for any person who is the primary handler of workers' compensation claims for an injured worker.

(5) Existing law authorizes collective bargaining agreements between a private employer or groups of employers engaged in the aerospace or timber industries and a recognized or certified exclusive bargaining representative that establish a dispute resolution process for workers' compensation instead of the hearing before the Workers' Compensation Appeals Board and its workers' compensation administrative law judges, or that provides for specified other alternative workers' compensation programs.

This bill would delete those provisions.

Existing law establishes similar provisions relating to collective bargaining agreements that provide for alternative workers' compensation programs, including vocational rehabilitation or retraining programs, applicable to employers engaged in construction, construction maintenance, or other related activities.

This bill would expand the applicability of these provisions by removing this industry limitation, but would eliminate vocational or retraining programs from those alternative workers' compensation programs included under the above provisions.

Existing law requires certain information in connection with these provisions to be submitted to the administrative director by an employer under penalty of perjury.

By expanding the definition of the crime of perjury, this bill would impose a state-mandated local program.

This bill, on and after January 1, 2004, would authorize any group of employers meeting specified criteria, notwithstanding any other provision of law, to submit an application to the Department of Industrial Relations to participate in an Alternative Workers' Compensation (AWR) program by entering into a written agreement with the department to provide a workers' compensation delivery system meeting prescribed requirements.

(6) Existing law defines "injury" for purposes of workers' compensation as including any injury or disease arising out of the employment.

This bill would revise this definition by specifying that the injury or disease arising out of the employment must be one that is certified by a physician using medical evidence based on objective medical findings.

(7) Existing law provides that workers' compensation law be liberally construed by the courts with the purpose of extending benefits for the protection of persons injured in the course of their employment.

This bill would provide that workers' compensation laws be liberally construed only after it is determined that an injury in the course of employment has occurred and the injury is both a "specific" injury, as defined, and results in serious physical or bodily harm.

(8) Existing workers' compensation law defines a cumulative injury as one that occurs as the result of repetitive mentally or physically traumatic activities extending over a period of time, the combined effect of which causes any disability or need for medical treatment.

This bill would provide that for a cumulative injury to be compensable, an employee is required to demonstrate by a preponderance of the evidence that the injury was substantially caused by actual activities of employment.

(9) Existing law provides for the compensation, under the workers' compensation laws, of workers suffering a psychiatric injury, if the employee establishes, by a preponderance of the evidence, specified matters.

This bill would, instead, require proof by clear and convincing evidence of specified matters in order to establish a psychiatric injury, including, among others, proof that the mental disorder arose out of, and in the course of, employment.

This bill would also require proof by clear and convincing evidence, rather than by a preponderance of the evidence, as to specified matters where the claim for compensation for a psychiatric injury occurring prior to the time of notice of termination or layoff is filed after notice of termination of employment or layoff, as specified.

(10) Existing law provides that whenever certain persons confined in the county jail, industrial farm, road camp, or city jail suffer injuries or death while working in the prevention or suppression of forest, brush, or grass fires, those persons shall be considered to be an employee of the county or city, respectively, for purposes of workers' compensation.

Existing law specifies the amount of average weekly earnings that are used in computing average annual earnings for the purposes of temporary disability indemnity benefits.

This bill would provide that for purposes of determining temporary disability benefits for any person entitled to benefits under the workers' compensation law as a result of an injury sustained by an inmate of any county jail, industrial farm, road camp, or city jail, or by an inmate assigned to a county work release program, the average weekly earnings shall be taken at the minimum amount set forth in the above provision regarding the calculation of temporary disability benefits, or the actual weekly wages lost due to disability resulting from the injury, whichever is less.

(11) Existing law establishes liability for compensation against an employer for the injury or death of an employee under specified circumstances, including where the injury is proximately caused by the employment and where the injury is not caused by the commission of a felony or a misdemeanor, as specified, by the injured employee for which he or she has been convicted.

This bill would revise these circumstances that establish liability for an employer to include instead where the employment is the predominant cause of the injury compared to all other causes combined, and where the injury is not caused by the commission of a criminal act by the injured employee for which he or she has been convicted.

(12) Existing law requires employers to provide for vocational rehabilitation services for qualified injured workers in specified circumstances and to provide these workers with a maintenance allowance, as specified.

This bill would make the provision of vocational rehabilitation services voluntary rather than mandatory at the option of the employer.

(13) Existing law generally provides for settlement and commutation of workers' compensation benefits, but does not allow settlement or commutation of prospective vocational rehabilitation services except upon a specified finding by a workers' compensation judge or upon an agreement by the employer and employee to a one-time payment under certain conditions.

This bill would delete the provision authorizing a one-time payment.

(14) Existing law provides that it is unlawful to commit various acts that compromise the integrity of the workers' compensation system, including presenting any knowingly false or fraudulent written or oral material statements in order to obtain or deny a claim for workers' compensation.

This bill would require an applicant for employment, upon the request of an employer, to disclose whether he or she has ever been adjudicated to have committed any of those unlawful acts or been convicted of violating other specified unlawful acts relating to fraud.

(15) Existing law requires employers to provide to an employee injured on the job health care treatment that is reasonably necessary to cure and relieve the effects of the injury. Existing law authorizes an employer to contract with a licensed health care organization for health care services to be provided to injured employees under workers' compensation laws and requires the health care organization to be certified for this purpose. Existing law also imposes various time limitations on employers with respect to the provision of medical care under the workers' compensation system.

Existing law establishes the Independent Medical Review System whereby enrollees of health care service plans may file grievances involving disputed health care services for determination by the independent medical review organization designated by the State Department of Health Services.

This bill would authorize an employer to contract with a preferred provider organization (PPO) for health care services to be provided to injured employees under the workers' compensation laws. The contract would be required to include, among other components, the opportunity for every employee to select a personal physician within the PPO network at any time and the right to a second opinion from a participating provider on a matter pertaining to diagnosis or treatment from a participating physician. It would also authorize an employer to enter into a contract with a health care organization that does not contain the time limitations imposed on the employer under the

workers' compensation law. The bill would permit any employee covered under these contracts, in the event of a disputed health care service, to request an independent medical review.

(16) Existing law requires an employer to provide all medical, surgical, chiropractic, acupuncture, and hospital treatment that is reasonably required to cure or relieve an employee from the effects of a work-related injury. Existing law provides that after 30 days from the date the injury is reported, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area, but that if an employee has notified his or her employer in writing prior to the date of injury that he or she has a personal physician, the employee shall have the right to be treated by that physician from the date of injury.

This bill would extend the time period before which an employee who has not previously notified the employer that he or she has a personal physician may be treated by his or her own physician or facility from 30 days to 120 days. It would also provide that if the employee has not notified the employer that he or she has a personal physician, then in the event of a disputed health care service, the employee may request an independent medical review, as specified.

(17) Existing law requires a pharmacy that provides medicines and medical supplies that are required to cure or relieve effects of an injury covered by workers' compensation to provide the generic drug equivalent, if available, unless the prescribing physician provides otherwise in writing.

This bill would instead provide that this requirement applies to any person or entity that dispenses medicines and medical supplies to a worker to cure or relieve the effects of an injury covered by workers' compensation, but would specify that compliance with this provision is not required under specified circumstances.

(18) Existing workers' compensation law requires a physician treating an injured employee to submit a report to the employer within 5 working days from the date of the initial examination.

This bill would require the physician to submit additional reports to the employer, as prescribed.

(19) Existing law requires the employer to make payment for medical treatment provided or authorized by the treating physician within 60 calendar days after receipt of the billing for the services together with any required reports and authorization.

This bill would change this payment timeframe requirement from within 60 to within 45 calendar days.

(20) Existing law provides that any properly documented amount billed that is not paid by the employer within the prescribed time period shall be increased by 10%, together with interest, unless the employer contests the items, as prescribed.

This bill would provide that if the employer contests, denies, or seeks review of the billing, the employer shall only be required to pay any interest or increase in compensation for delayed payment pursuant to this provision if the provider objects in writing to the employer's written explanation for contesting, denying, or seeking review of the billing within 45 calendar days of receipt of payment, notice of nonpayment, or explanation of review. The bill would preclude the provider from seeking further reimbursement or filing a lien if the provider fails to make this objection within the 45 calendar day period.

(21) Existing law provides that when payment of compensation has been unreasonably delayed or refused, the full amount of the order, decision, or award shall be increased by 10%. Existing law requires the appeals board to determine the question of delay and reasonableness and to award reasonable attorney's fees incurred in enforcing the payment of compensation awarded.

This bill would repeal these provisions. The bill, instead, would prescribe procedures under which, when the payment of compensation has been unreasonably delayed or refused, the amount of the payment unreasonably delayed or refused may be increased up to 25% or $500, whichever is greater. The bill would require the appeals board to use its discretion in order to accomplish fair balance and substantial justice between the parties under these proceedings.

(22) Existing law requires the administrative director to adopt and revise, no less frequently than biennially, an official medical fee schedule that establishes reasonable maximum fees paid for medical services through the workers' compensation system.

This bill would require all medical services provided to a worker from the date of injury to be subject to the official medical fee schedule, regardless of the date the injury is accepted as, or determined to be, compensable. It would prohibit the total payment to the provider of medical services from exceeding the maximum reasonable fees listed in the official medical fee schedule. The bill would require the administrative director to include in the schedule, on or before January 1, 2005, services for outpatient surgery facilities and emergency room

facilities, as well as pharmacy services and products, durable medical equipment, ambulance services, and home health care services. The bill would impose certain requirements on the administrative director when revising the schedule.

(23) Existing law requires the administrative director to consult with statewide professional organizations representing affected providers on the update of the fee schedule.

This bill would require the administrative director to consult with the Industrial Medical Council prior to the adoption of any update of the medical fee schedule. It would also require the council to hold a public hearing no less than 45 days before the date of the proposed adoption of the update to give interested parties the opportunity for comment.

(24) Existing law authorizes a medical provider or a licensed health care facility to be paid fees by an employer or carrier that are in excess of those set forth on the official medical fee schedule if certain conditions are met.

This bill would prohibit the total payment to the provider of medical services from exceeding the maximum reasonable fees listed in the official medical fee schedule, except as provided. It would also authorize a medical provider or a licensed health care facility to be paid a fee by an employer or carrier in the event that a service is not set forth on the official medical fee schedule, if the fee is reasonable, as specified.

(25) Existing law provides that the administrative director shall have the sole authority to develop an outpatient surgery facility fee schedule for services not performed under contract, provided that the schedule meets specified requirements.

This bill would delete this provision.

(26) Existing law also requires the administrative director to adopt a pharmaceutical fee schedule and a medical-legal fee schedule.

This bill would require the Medical Director of the Industrial Medical Council, on or before June 4, 2004, to recommend to the administrative director guidelines for the diagnosis and treatment of industrial injuries and model utilization and review protocols. The bill would require the administrative director, by July 1, 2004, to adopt an official utilization schedule based on these guidelines and protocols. It would also provide that in the event of a disputed medical service in connection with the utilization schedule, an employee may request an independent medical review, as specified.

(27) Existing law provides that the appeals board has jurisdiction to determine workers' compensation claims, including determinations regarding apportionment of injury.

This bill would provide that in denying apportionment, the appeals board may not, in determining permanent disability, rely on any medical report that fails to fully address the issue of apportionment and fails to set forth the basis for the medical opinion, on any medical report that fails to apportion a previous injury or illness that has been the subject of a prior claim for damages, or on any medical report that fails to provide a discussion of the medical processes by which a previously asserted injury or illness resolved without affecting bodily function.

This bill would provide that if an applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury. The bill would also prohibit the accumulation of all permanent disability awards issued to one individual employee from exceeding 100% unless the employee's injury or illness is conclusively presumed to be total in character.

This bill would prohibit the payment of permanent disability and death benefits unless the industrial injury is the predominant cause of the death or disability when compared to all causes of injury in total.

(28) Existing law specifies which party must bear the burden of proof in various aspects of workers' compensation proceedings.

This bill would provide that the burden of proof for apportionment regarding permanent disability, as specified, shall rest on the defendant and would specify the standard of proof.

(29) Existing law provides for the submission of evaluations and reports to the appeals board by an employee's treating physician and an independent medical evaluator for purposes of determining the extent of an employee's permanent disability.

This bill would require, on and after January 1, 2004, that all evaluations and reports prepared by a physician with regard to the degree of permanent whole body impairment that an employee has sustained be based upon demonstrable medical evidence that indicates how the impairment restricts the function of the body or its members, organs, or psyche. The bill would require the physician to use established medical guidelines in accordance with specified publications, and would provide that deviations from the guidelines contained in publications shall not constitute a basis for excluding evidence from consideration, but would be considered in determining

the weight given to that evidence. It would also prohibit disability ratings from being based on all evaluations and reports that do not follow the established medical guidelines contained in these publications, and would provide that failure by a physician to comply with these provisions may result in the disapproval of the physician's fee for the evaluation or report.

(30) The California Constitution requires the state to reimburse local agencies and school districts for certain costs mandated by the state. Statutory provisions establish procedures for making that reimbursement.

This bill would provide that no reimbursement is required by this act for a specified reason.

Vote: majority. Appropriation: no. Fiscal committee: yes. State-mandated local program: yes.

The people of the State of California do enact as follows:

~~SECTION 1. Section 139.3 of the Labor Code is amended to~~

SECTION 1. Section 139.15 is added to the Labor Code, to read:

139.15. (a) On or before June 4, 2004, the medical director shall recommend to the administrative director guidelines for the diagnosis and treatment of industrial injuries. Diagnostic and treatment guidelines shall be based upon the best available scientific evidence and a consensus of expert opinion. In developing these guidelines, the medical director shall consider all of the following:

(1) Scientific evidence, including reports and studies published in peer-reviewed scientific and clinical literature, taking into consideration the nature and quality of the study, its methodology and rigorousness of design, as well as the quality of the journal in which the study was published regarding the following:

(A) For treatment services, studies addressing safety, efficacy, and effectiveness of the treatment or procedure for its intended use shall be considered.

(B) For diagnostic devices or procedures, studies addressing safety, technical capacity, accuracy, or utility of the device or procedure for its intended use shall be considered.

(2) National and community-based opinion, including, but not limited to, syntheses of clinical issues that may take the form of

published reports in the scientific literature, national consensus documents, formalized documents addressing standards of practice, practice parameters from professional societies or commissions, and technology assessments produced by independent evidence-based practice centers. The medical director shall evaluate the nature and quality of the process used to reach consensus or produce the synthesis of expert opinion and shall take into consideration the qualifications of participants, potential biases of sponsoring organizations, the inclusion of graded scientific information in the deliberations, the explicit nature of the document, and the processes used for broader review.

(3) Advice and recommendations of formal committees made up of providers within the state. As appropriate to the subject matter, this may include recommendations from the Industrial Medical Council, other state agencies, federal agencies, and any other entity regarding studies, experience, and practice with past coverage.

(b) In developing the guidelines required by this section, the greatest weight shall be given to the most rigorously designed studies and to those studies that are reproducible.

(c) The medical director, by rule, may specifically identify any medical treatment found to be unscientific, unproven, outmoded, or experimental for purposes of determining whether that treatment is reasonable. Any treatment so identified shall be presumed to be unreasonable in any dispute involving the appropriateness of treatment.

(d) (1) The medical director shall develop and recommend to the administrative director model utilization review protocols. The protocols shall include procedures for the evaluation and determination of the reasonableness, necessity, and appropriateness of a worker's use of medical care resources and the provision of any needed assistance to the provider or injured worker, or both, to ensure appropriate use of resources. Utilization review protocols shall include prior authorization, concurrent review, retrospective review, discharge planning, and case management activities. These protocols shall also facilitate the use of treatment guidelines proposed pursuant to subdivision (c). The protocols developed by the medical director shall be submitted for accreditation to the American Accreditation Health Care Commission or other national accrediting body. Once these

protocols are accredited, the protocols shall be submitted to the administrative director for adoption as regulations.

(2) The medical director shall also consult with the Industrial Medical Council in the development of utilization review protocols. Once these protocols are developed, the medical director shall include information on the use of these protocols, and any additional protocols developed pursuant to paragraph (3), in any educational materials development for providers of medical care.

(3) Claims payers may develop utilization protocols different from the model protocols developed pursuant to this section. Protocols developed by payers shall be submitted to, and accredited by, the American Accreditation Health Care Commission or other national accrediting body prior to use. These protocols shall also be submitted to the medical director within 30 days of accreditation. The medical director shall provide to statewide organizations representing providers of medical care copies of all of these accredited protocols. In addition, payers that use the model protocols developed pursuant to this section shall also notify the medical director of the decision to use these protocols within 30 days of their development. The medical director shall also provide this information to statewide organizations representing providers of medical care.

(e) The administrative director, after notice and public hearing, shall adopt regulations implementing the recommendations of the medical director as set forth in this section within 90 days of receipt of the recommendations. The administrative director may adopt treatment guidelines or model utilization review protocols other than those recommended by the medical director if substantial evidence is presented at the rulemaking hearing that the treatment guidelines or utilization review protocols do not represent best evidence-based medical practice or national standards for the review of medical treatment. All medical treatment procedures compensable under Division 4 (commencing with Section 3200) shall be subject to the treatment guidelines and utilization review protocols as set forth in this section regardless of the date of injury.

SEC. 2. Section 139.3 of the Labor Code is amended to read:

139.3. (a) Notwithstanding any other provision of law, to the extent those services are paid pursuant to Division 4 (commencing with Section 3200), it is unlawful for a physician to refer a person

for *outpatient surgery,* clinical laboratory, diagnostic nuclear medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services whether for treatment or medical-legal purposes if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral.

(b) For purposes of this section and Section 139.31, the following shall apply:

(1) ''Diagnostic imaging'' includes, but is not limited to, all X-ray, computed axial tomography magnetic resonance imaging, nuclear medicine, positron emission tomography, mammography, and ultrasound goods and services.

(2) ''Immediate family'' includes the spouse and children of the physician, the parents of the physician, and the spouses of the children of the physician.

(3) ''Physician'' means a physician as defined in Section 3209.3.

(4) A ''financial interest'' includes, but is not limited to, any type of ownership, interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and a person or entity to whom the physician refers a person for a good or service specified in subdivision (a). A financial interest also exists if there is an indirect relationship between a physician and the referral recipient, including, but not limited to, an arrangement whereby a physician has an ownership interest in any entity that leases property to the referral recipient. Any financial interest transferred by a physician to, or otherwise established in, any person or entity for the purpose of avoiding the prohibition of this section shall be deemed a financial interest of the physician.

(5) A ''physician's office'' is either of the following:

(A) An office of a physician in solo practice.

(B) An office in which the services or goods are personally provided by the physician or by employees in that office, or personally by independent contractors in that office, in accordance with other provisions of law. Employees and independent contractors shall be licensed or certified when that licensure or certification is required by law.

(6) The ‘‘office of a group practice’’ is an office or offices in which two or more physicians are legally organized as a partnership, professional corporation, or not-for-profit corporation licensed according to subdivision (a) of Section 1204 of the Health and Safety Code for which all of the following are applicable:

(A) Each physician who is a member of the group provides substantially the full range of services that the physician routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel.

(B) Substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group, and except that in the case of multispecialty clinics, as defined in subdivision (*l*) of Section 1206 of the Health and Safety Code, physician services are billed in the name of the multispecialty clinic and amounts so received are treated as receipts of the multispecialty clinic.

(C) The overhead expenses of, and the income from, the practice are distributed in accordance with methods previously determined by members of the group.

(c) (1) It is unlawful for a licensee to enter into an arrangement or scheme, such as a cross-referral arrangement, that the licensee knows, or should know, has a principal purpose of ensuring referrals by the licensee to a particular entity that, if the licensee directly made referrals to that entity, would be in violation of this section.

(2) It shall be unlawful for a physician to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for a referred evaluation or consultation.

(d) No claim for payment shall be presented by an entity to any individual, third-party payor, or other entity for a good or service furnished pursuant to a referral prohibited under this section.

(e) A physician who refers to, or seeks consultation from, an organization in which the physician has a financial interest shall disclose this interest to the patient or if the patient is a minor, to the

patient's parents or legal guardian in writing at the time of the referral.

(f) No insurer, self-insurer, or other payor shall pay a charge or lien for any good or service resulting from a referral in violation of this section.

(g) A violation of subdivision (a) shall be a misdemeanor. The appropriate licensing board shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Violations of this section may also be subject to civil penalties of up to five thousand dollars ($5,000) for each offense, which may be enforced by the Insurance Commissioner, Attorney General, or a district attorney. A violation of subdivision (c), (d), (e), or (f) is a public offense and is punishable upon conviction by a fine not exceeding fifteen thousand dollars ($15,000) for each violation and appropriate disciplinary action, including revocation of professional licensure, by the Medical Board of California or other appropriate governmental agency.

SEC. 3. Section 139.5 of the Labor Code is amended to read:

139.5. (a) The administrative director shall establish a vocational rehabilitation unit, which shall include appropriate professional staff, and ~~which~~ *that* shall have the following duties:

(1) To foster, review, and approve vocational rehabilitation plans developed by a qualified rehabilitation representative of the employer, insurer, state agency, or employee. Plans agreed to by the employer and employee do not require approval by the vocational rehabilitation unit unless the employee is unrepresented.

(2) To develop rules and regulations, to be promulgated by the administrative director, providing for a procedure in which an employee may waive the services of a qualified rehabilitation representative where the employee has been enrolled and made substantial progress toward completion of a degree or certificate from a community college, California State University, or the University of California and desires a plan to complete the degree or certificate. These rules and regulations shall provide that this waiver as well as any plan developed without the assistance of a qualified rehabilitation representative must be approved by the rehabilitation unit.

(3) To develop rules and regulations, to be promulgated by the administrative director, which would expedite and facilitate the identification, notification and referral of industrially injured employees to vocational rehabilitation services.

(4) To coordinate and enforce the implementation of vocational rehabilitation plans.

(5) To develop a fee schedule, to be promulgated by the administrative director, governing reasonable fees for vocational rehabilitation services provided on and after January 1, 1991. The initial fee schedule promulgated under this paragraph shall be designed to reduce the cost of vocational rehabilitation services by 10 percent from the level of fees paid during 1989. On or before July 1, 1994, the administrative director shall establish the maximum aggregate permissible fees that may be charged for counseling. Those fees shall not exceed four thousand five hundred dollars ($4,500) and shall be included within the sixteen thousand dollar ($16,000) cap. The fee schedule shall permit up to (A) three thousand dollars ($3,000) for vocational evaluation, evaluation of vocational feasibility, initial interview, vocational testing, counseling and research for plan development, and preparation of the Division of Workers' Compensation Form 102, and (B) three thousand five hundred dollars ($3,500) for plan monitoring, job seeking skills, and job placement research and counseling. However, in no event shall the aggregate of (A) and (B) exceed four thousand five hundred dollars ($4,500).

(6) To develop standards, to be promulgated by the administrative director, for governing the timeliness and the quality of vocational rehabilitation services.

(b) The salaries of the personnel of the vocational rehabilitation unit shall be fixed by the Department of Personnel Administration.

(c) When an employee is determined to be medically eligible and chooses to participate in a vocational rehabilitation program *and his or her employer offers a vocational rehabilitation program*, he or she shall continue to receive temporary disability indemnity payments only until his or her medical condition becomes permanent and stationary and, thereafter, may receive a maintenance allowance. Rehabilitation maintenance allowance payments shall begin after the employee's medical condition becomes permanent and stationary, upon a request for vocational rehabilitation services. Thereafter, the maintenance allowance

shall be paid for a period not to exceed 52 weeks in the aggregate, except where the overall cap on vocational rehabilitation services can be exceeded under this section or Section 4642 or subdivision (d) or (e) of Section 4644.

The employee also shall receive additional living expenses necessitated by the vocational rehabilitation services, together with all reasonable and necessary vocational training, at the expense of the employer, but in no event shall the expenses, counseling fees, training, maintenance allowance, and costs associated with, or arising out of, vocational rehabilitation services incurred after the employee's request for vocational rehabilitation services, except temporary disability payments, exceed sixteen thousand dollars ($16,000). The administrative director shall adopt regulations to ensure that the continued receipt of vocational rehabilitation maintenance allowance benefits is dependent upon the injured worker's regular and consistent attendance at, and participation in, his or her vocational rehabilitation program.

(d) The amount of the maintenance allowance due under subdivision (c) shall be two-thirds of the employee's average weekly earnings at the date of injury payable as follows:

(1) The amount the employee would have received as continuing temporary disability indemnity, but not more than two hundred forty-six dollars ($246) a week for injuries occurring on or after January 1, 1990.

(2) At the employee's option, an additional amount from permanent disability indemnity due or payable, sufficient to provide the employee with a maintenance allowance equal to two-thirds of the employee's average weekly earnings at the date of injury subject to the limits specified in subdivision (a) of Section 4453 and the requirements of Section 4661.5. In no event shall temporary disability indemnity and maintenance allowance be payable concurrently.

If the employer disputes the treating physician's determination of medical eligibility, the employee shall continue to receive that portion of the maintenance allowance payable under paragraph (1) pending final determination of the dispute. If the employee disputes the treating physician's determination of medical eligibility and prevails, the employee shall be entitled to that portion of the maintenance allowance payable under paragraph (1)

retroactive to the date of the employee's request for vocational rehabilitation services. These payments shall not be counted against the maximum expenditures for vocational rehabilitation services provided by this section.

(e) No provision of this section nor of any rule, regulation, or vocational rehabilitation plan developed or promulgated under this section nor any benefit provided pursuant to this section shall apply to an injured employee whose injury occurred prior to January 1, 1975. Nothing in this section shall affect any plan, benefit, or program authorized by this section as added by Chapter 1513 of the Statutes of 1965 or as amended by Chapter 83 of the Statutes of 1972.

(f) The time within which an employee may request vocational rehabilitation services *if his or her employer chooses to offer them* is set forth in Sections 5405.5, 5410, and 5803.

(g) An offer of a job within state service to a state employee in State Bargaining Unit 1, 4, 15, 18, or 20 at the same or similar salary and the same or similar geographic location is a prima facie offer of vocational rehabilitation under this statute.

(h) It shall be unlawful for a qualified rehabilitation representative or rehabilitation counselor to refer any employee to any work evaluation facility or to any education or training program if the qualified rehabilitation representative or rehabilitation counselor, or a spouse, employer, coemployee, or any party with whom he or she has entered into contract, express or implied, has any proprietary interest in or contractual relationship with the work evaluation facility or education or training program. It shall also be unlawful for any insurer to refer any injured worker to any rehabilitation provider or facility if the insurer has a proprietary interest in the rehabilitation provider or facility or for any insurer to charge against any claim for the expenses of employees of the insurer to provide vocational rehabilitation services unless those expenses are disclosed to the insured and agreed to in advance.

(i) Any charges by an insurer for the activities of an employee who supervises outside vocational rehabilitation services shall not exceed the vocational rehabilitation fee schedule, and shall not be counted against the overall cap for vocational rehabilitation or the limit on counselor's fees provided for in this section. These charges shall be attributed as expenses by the insurer and not losses

for purposes of insurance rating pursuant to Article 2 (commencing with Section 11730) of Chapter 3 of Division 2 of the Insurance Code.

(j) Any costs of an employer of supervising vocational rehabilitation services shall not be counted against the overall cap for vocational rehabilitation or the limit on counselor's fees provided for in this section.

(k) Notwithstanding any other provision of law, an employer is not required to comply with requirements concerning vocational rehabilitation unless he or she elects to offer vocational rehabilitation services.

SEC. 4. Section 139.7 is added to the Labor Code, to read:

139.7. (a) On and after January 1, 2006, every physician who treats and evaluates injured workers shall be certified by the Industrial Medical Council as a Qualified Workers' Compensation Physician (QWCP), unless this requirement has been waived, or the physician is exempted from the QWCP certification requirement, pursuant to subdivision (f).

(b) The Industrial Medical Council shall certify a physician as a QWCP upon completion of the course specified in Section 139.71, passage of an examination written and administered by the council, and the completion of 10 ratable reports.

(c) Certification shall be valid for two years. The Industrial Medical Council shall recertify a QWCP upon completion of a recertification course, as specified by the council.

(d) (1) On and after January 1, 2006, only a QWCP shall be eligible for reimbursement under Division 4 (commencing with Section 3200).

(2) Notwithstanding paragraph (1), a physician who is not a QWCP may be reimbursed for a first visit and for providing urgent care, as specified in regulations adopted by the administrative director in consultation with the Industrial Medical Council.

(e) A physician who provides medical treatment to an injured worker, but who does not participate in the evaluation of the injured worker for the purpose of determining workers' compensation benefits or participate in making determinations for purposes of workers' compensation, such as with regard to temporary or disability benefit ratings, is exempt from the requirements of this section.

(f) (1) The Industrial Medical Council may grant a waiver from the certification requirements of this section to a physician who is in an area in which the council has determined there is a shortage of physicians certified under this section who are available to treat and evaluate injured workers.

(2) A physician who is a qualified medical evaluator, as defined in subdivision (e) of Section 110, shall be exempt from the QWCP certification requirement.

SEC. 5. Section 139.71 is added to the Labor Code, to read:

139.71. (a) On or before January 1, 2005, the Industrial Medical Council shall establish a Qualified Workers' Compensation Physician (QWCP) certification program. The program shall consist of certification and recertification courses, as well as a certification examination.

(b) The certification and recertification courses shall demonstrate competence in the diagnosis and treatment of occupational injuries, the use of treatment guidelines, determination of the nature and duration of temporary disability benefits, determination of work restrictions and assessment of a worker's ability to return to work, determination of when a worker's condition is permanent and stationary, evaluation of permanent disability, and accurate and complete report writing. The curriculum shall be determined by the council and shall be consistent with the scope of practice of physicians within the workers' compensation system including, but not limited to, Section 3209.3.

(c) The council shall approve those individuals and entities that are authorized to provide courses for certification and recertification.

SEC. 6. Section 139.72 is added to the Labor Code, to read:

139.72. (a) On or before January 1, 2005, the administrative director shall contract, to the extent permitted by state law, with a public or private university or policy institute in the state to develop physician utilization management, quality of care, billing, and outcome measurement data.

(b) On or before July 1, 2006, and annually thereafter, the administrative director shall publish a report that includes the data specified in subdivision (a). It is the intent of the Legislature that this ongoing process be designed and implemented to

encourage best medical practices and to discourage unnecessary variance in treatment patterns.

(c) The administrative director shall ensure the confidentiality and protection of patient-specific data.

SEC. 7. Section 139.73 is added to the Labor Code, to read:

139.73. (a) On or before January 1, 2005, the administrative director shall establish a mandatory annual training program for persons in the Disability Evaluation Unit within the Division of Workers' Compensation of the Department of Industrial Relations who determine permanent disability ratings for an injured worker.

(b) The annual disability evaluation unit training program shall include but not be limited to, instruction on the medical-legal aspects of the workers' compensation system and instruction on consistent and fair application of the permanent disability guidelines.

(c) The administrative director shall approve the persons or entities that are authorized to provide the training program and their program curricula.

SEC. 8. Section 139.74 is added to the Labor Code, to read:

139.74. (a) On or before January 1, 2005, the administrative director shall establish a mandatory annual insurance claim administrator training program for any person who is the primary handler of an injured workers' compensation claim.

(b) The annual insurance claim administrator training program shall include, but not be limited to, instruction on the medical coordination of workers' compensation claims, permanent disability guidelines, and the medical-legal aspect of the workers' compensation system.

(c) The administrative director shall approve the persons and entities that are authorized to provide the training program, and the providers' program curricula.

SEC. 9. Section 3201.5 of the Labor Code is amended to read:

3201.5. (a) Except as provided in subdivisions (b) and (c), the Department of Industrial Relations and the courts of this state shall recognize as valid and binding any provision in a collective bargaining agreement between a private employer or groups of employers ~~engaged in construction, construction maintenance, or activities limited to rock, sand, gravel, cement and asphalt operations, heavy-duty mechanics, surveying, and construction~~

~~inspection~~ and a union that is the recognized or certified exclusive bargaining representative that establishes any of the following:

(1) An alternative dispute resolution system governing disputes between employees and employers or their insurers that supplements or replaces all or part of those dispute resolution processes contained in this division, including, but not limited to, mediation and arbitration. Any system of arbitration shall provide that the decision of the arbiter or board of arbitration is subject to review by the appeals board in the same manner as provided for reconsideration of a final order, decision, or award made and filed by a workers' compensation administrative law judge pursuant to the procedures set forth in Article 1 (commencing with Section 5900) of Chapter 7 of Part 4 of Division 4, and the court of appeals pursuant to the procedures set forth in Article 2 (commencing with Section 5950) of Chapter 7 of Part 4 of Division 4, governing orders, decisions, or awards of the appeals board. The findings of fact, award, order, or decision of the arbitrator shall have the same force and effect as an award, order, or decision of a workers' compensation administrative law judge. Any provision for arbitration established pursuant to this section shall not be subject to Sections 5270, 5270.5, 5271, 5272, 5273, 5275, and 5277.

(2) The use of an agreed list of providers of medical treatment that may be the exclusive source of all medical treatment provided under this division.

(3) The use of an agreed, limited list of qualified medical evaluators and agreed medical evaluators that may be the exclusive source of qualified medical evaluators and agreed medical evaluators under this division.

(4) Joint labor management safety committees.

(5) A light-duty, modified job or return-to-work program.

~~(6) A vocational rehabilitation or retraining program utilizing an agreed list of providers of rehabilitation services that may be the exclusive source of providers of rehabilitation services under this division.~~

(b) Nothing in this section shall allow a collective bargaining agreement that diminishes the entitlement of an employee to compensation payments for total or partial disability, temporary disability, vocational rehabilitation, or medical treatment fully paid by the employer as otherwise provided in this division. The

portion of any agreement that violates this subdivision shall be declared null and void.

(c) Subdivision (a) shall apply only to the following:

(1) An employer developing or projecting an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars ($250,000) or more, or any employer that paid an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars ($250,000) in at least one of the previous three years.

(2) Groups of employers engaged in a workers' compensation safety group complying with Sections 11656.6 and 11656.7 of the Insurance Code, and established pursuant to a joint labor management safety committee or committees, that develops or projects annual workers' compensation insurance premiums of two million dollars ($2,000,000) or more.

(3) Employers or groups of employers that are self-insured in compliance with Section 3700 that would have projected annual workers' compensation costs that meet the requirements of, and that meet the other requirements of, paragraph (1) in the case of employers, or paragraph (2) in the case of groups of employers.

(4) Employers covered by an owner or general contractor provided wrap-up insurance policy applicable to a single construction site that develops workers' compensation insurance premiums of two million dollars ($2,000,000) or more with respect to those employees covered by that wrap-up insurance policy.

(d) Employers and labor representatives who meet the eligibility requirements of this section shall be issued a letter by the administrative director advising each employer and labor representative that, based upon the review of all documents and materials submitted as required by the administrative director, each has met the eligibility requirements of this section.

(e) The premium rate for a policy of insurance issued pursuant to this section shall not be subject to the requirements of Section 11732 or 11732.5 of the Insurance Code.

(f) No employer may establish or continue a program established under this section until it has provided the administrative director with all of the following:

(1) Upon its original application and whenever it is renegotiated thereafter, a copy of the collective bargaining

agreement and the approximate number of employees who will be covered thereby.

(2) Upon its original application and annually thereafter, a valid and active license where that license is required by law as a condition of doing business in the state ~~within the industries set forth in subdivision (a) of Section 3201.5~~.

(3) Upon its original application and annually thereafter, a statement signed under penalty of perjury, that no action has been taken by any administrative agency or court of the United States to invalidate the collective bargaining agreement.

(4) The name, address, and telephone number of the contact person of the employer.

(5) Any other information that the administrative director deems necessary to further the purposes of this section.

(g) No collective bargaining representative may establish or continue to participate in a program established under this section unless all of the following requirements are met:

(1) Upon its original application and annually thereafter, it has provided to the administrative director a copy of its most recent LM-2 or LM-3 filing with the United States Department of Labor, along with a statement, signed under penalty of perjury, that the document is a true and correct copy.

(2) It has provided to the administrative director the name, address, and telephone number of the contact person or persons of the collective bargaining representative or representatives.

(h) Commencing July 1, 1995, and annually thereafter, the Division of Workers' Compensation shall report to the Director of the Department of Industrial Relations the number of collective bargaining agreements received and the number of employees covered by these agreements.

(i) By June 30, 1996, and annually thereafter, the Administrative Director of the Division of Workers' Compensation shall prepare and notify Members of the Legislature that a report authorized by this section is available upon request. The report based upon aggregate data shall include the following:

(1) Person hours and payroll covered by agreements filed.

(2) The number of claims filed.

(3) The average cost per claim shall be reported by cost components whenever practicable.

(4) The number of litigated claims, including the number of claims submitted to mediation, the appeals board, or the court of appeal.

(5) The number of contested claims resolved prior to arbitration.

(6) The projected incurred costs and actual costs of claims.

(7) Safety history.

(8) The number of workers participating in vocational rehabilitation.

(9) The number of workers participating in light-duty programs.

The division shall have the authority to require those employers and groups of employers listed in subdivision (c) to provide the data listed above.

(j) The data obtained by the administrative director pursuant to this section shall be confidential and not subject to public disclosure under any law of this state. However, the Division of Workers' Compensation shall create derivative works pursuant to subdivisions (h) and (i) based on the collective bargaining agreements and data. Those derivative works shall not be confidential, but shall be public. On a monthly basis the administrative director shall make available an updated list of employers and unions entering into collective bargaining agreements containing provisions authorized by this section.

SEC. 10. Section 3201.6 is added to the Labor Code, to read:

3201.6. (a) Notwithstanding any other provision of law, on and after January 1, 2004, any group of private employers that has paid an aggregate of two hundred fifty thousand dollars ($250,000) or more in annual workers' compensation insurance premiums, in California, in at least one of the previous three years and for which 50 percent or more of its employees are not represented by a union that is the recognized or certified exclusive bargaining representative, may submit an application to the Department of Industrial Relations to participate in an Alternative Workers' Compensation (AWC) program. The courts of this state and the department shall recognize as valid and binding a written agreement between such a group of employers and the department that establishes an AWC program to ensure an effective and efficient program to provide a workers' compensation delivery system for the benefit of employees and the employers covered by

the agreement. The department shall approve an application for any agreement that includes, at a minimum, the following provisions:

(1) A list of authorized medical providers designated in the agreement to be the exclusive source of medical treatment, except for the provision of first aid and emergency care, as required by Section 4600. The list of authorized providers shall contain a sufficient number of providers in the following specialties:

(A) Orthopedics.

(B) Neurology.

(C) Neurosurgery.

(D) Ophthalmology.

(E) Cardiology.

(F) Internal medicine.

(G) Dermatology.

(H) Radiology.

(I) Chiropractic medicine.

(J) General or family practice.

(K) Psychiatry.

(L) Pulmonary or respiratory medicine.

(M) Occupational medicine.

(N) Oncology.

(2) A requirement that all prescription medications furnished as a result of injuries subject to the agreement shall be furnished by the workers' compensation insurer through an authorized pharmacist or network of pharmacies that meet certain access standards, as determined by the department.

(3) A requirement that the opinions and recommendations of the authorized provider selected in accordance with the agreement shall bind both the insurer and the employee. In the event of a disagreement with the authorized provider's opinions or recommendations, the employee's sole recourse shall be to obtain a second opinion from another authorized provider in the same specialty as that of the first provider and to present the second opinion in accordance with procedures contained in an Alternative Dispute Resolution (ADR) program, which shall be established by the agreement pursuant to paragraph (4).

(4) A requirement that an ADR program be utilized in place of, and to the exclusion of, the Division of Workers' Compensation hearing and dispute resolution procedures, with review of all ADR

program decisions by the appeals board and the court of appeal, as requested by the parties. The ADR program shall be used in place of the filing of an Application for Adjudication of Claim with the appeals board. Any claim filed with the appeals board by an employee subject to the agreement may immediately be removed on motion of the insurer and processed in accordance with the ADR program established by the agreement. The ADR program shall apply to all compensable, work-related injuries, including occupational disease, sustained by employees while working under, and covered by, the agreement. The department shall adopt regulations regarding claims adjudication procedures in the event an agreement is terminated by a group of employers or the department.

(5) A requirement that the ADR program consist of a process for the selection and timely issuance of decisions by impartial mediators and arbitrators, as specified by the department.

(b) The Director of Industrial Relations may terminate an agreement upon the issuance of written findings and evidence that the agreement is not being implemented in accordance with its provisions.

SEC. 11. Section 3201.7 of the Labor Code, as added by Chapter 6 of the Statutes of 2002, is repealed.

~~3201.7. (a) Except as provided in subdivisions (b) and (c), the Department of Industrial Relations and the courts of this state shall recognize as valid and binding any provision in a collective bargaining agreement between a private employer or groups of employers engaged in the aerospace or timber industries and a union that is the recognized or certified exclusive bargaining representative that establishes any of the following:~~

~~(1) An alternative dispute resolution system governing disputes between employees and employers or their insurers that supplements or replaces all or part of those dispute resolution processes contained in this division, including, but not limited to, mediation and arbitration. Any system of arbitration shall provide that the decision of the arbiter or board of arbitration is subject to review by the appeals board in the same manner as provided for reconsideration of a final order, decision, or award made and filled by a workers' compensation judge pursuant to the procedures set forth in Article 1 (commencing with Section 5900) of Chapter 7 of Part 4 of Division 4, and the court of appeals pursuant to the~~

~~procedures set forth in Article 2 (commencing with Section 5950) of Chapter 7 of Part 4 of Division 4, governing orders, decisions, or awards of the appeals board. The findings of fact, award, order, or decision of the arbitrator shall have the same force and effect as an award, order, or decision of a workers' compensation administrative law judge. Any provision for arbitration established pursuant to this section shall not be subject to Sections 5270, 5270.5, 5271, 5272, 5273, 5275, and 5277.~~

~~(2) The use of an agreed list of providers of medical treatment that may be the exclusive source of all medical treatment provided under this division.~~

~~(3) The use of an agreed, limited list of qualified medical evaluators and agreed medical evaluators that may be the exclusive source of qualified medical evaluators and agreed medical evaluators under this division.~~

~~(4) Joint labor management safety committees.~~

~~(5) A light-duty, modified job or return-to-work program.~~

~~(6) A vocational rehabilitation or retraining program utilizing an agreed list of providers of rehabilitation services that may be the exclusive source of providers of rehabilitation services under this division.~~

~~(b) Nothing in this section shall allow a collective bargaining agreement that diminishes the entitlement of an employee to compensation payments for total or partial disability, temporary disability, vocational rehabilitation, or medical treatment fully paid by the employer as otherwise provided in this division; nor shall any agreement authorized by this section deny to any employee the right to representation by counsel at all stages of the alternative dispute resolution process. The portion of any agreement that violates this subdivision shall be declared null and void.~~

~~(c) Subdivision (a) shall apply only to the following:~~

~~(1) An employer developing or projecting an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars ($250,000) or more, or any employer that paid an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars ($250,000), in at least one of the previous three years.~~

~~(2) Groups of employers engaged in a workers' compensation safety group complying with Sections 11656.6 and 11656.7 of the~~

~~Insurance Code, and established pursuant to a joint labor management safety committee or committees, which develops or projects annual workers' compensation insurance premiums of two million dollars ($2,000,000) or more.~~

~~(3) Employer or groups of employers that are self-insured in compliance with Section 3700 that would have projected annual workers' compensation costs that meet the requirements of paragraph (1) in the case of employers, or paragraph (2) in the case of groups of employers.~~

~~(d) Employers and labor representatives who meet the eligibility requirements of this section shall be issued a letter by the administrative director advising each employer and labor representative that, based upon the review of all documents and materials submitted as required by the administrative director, each has met the eligibility requirements of this section.~~

~~(e) The premium rate for a policy of insurance issued pursuant to this section shall not be subject to the requirements of Section 11732 or 11732.4 of the Insurance Code.~~

~~(f) No employer may establish or continue a program established under this section until it has provided the administrative director with all of the following:~~

~~(1) Upon its original application and whenever it is renegotiated thereafter, a copy of the collective bargaining agreement and the approximate number of employees who will be covered thereby.~~

~~(2) Upon its original application and annually thereafter, a valid and active license where that license is required by law as a condition of doing business in the state within the industries set forth in subdivision (a).~~

~~(3) Upon its original application and annually thereafter, a statement signed under penalty of perjury, that no action has been taken by any administrative agency or court of the United States to invalidate the collective bargaining agreement.~~

~~(4) The name, address, and telephone number of the contact person of the employer.~~

~~(5) Upon its original application, a plan agreed to between an employer and any affected union prior to the commencement of collective bargaining, that establishes a framework for the implementation of the system to be developed pursuant to subdivision (a).~~

~~(6) Any other information that the administrative director deems necessary to further the purposes of this section.~~

~~(g) No collective bargaining representative may establish or continue to participate in a program established under this section unless all of the following requirements are met:~~

~~(1) Upon its original application and annually thereafter, it has provided to the administrative director a copy of its most recent LM-2 or LM-3 filing with the United States Department of Labor, along with a statement, signed under penalty of perjury, that the document is a true and correct copy.~~

~~(2) It has provided to the administrative director the name, address, and telephone number of the contact person or persons of the collective bargaining representative or representatives.~~

~~(h) Commencing July 1, 2004, and annually thereafter, the Division of Workers' Compensation shall report to the Director of Industrial Relations the number of collective bargaining agreements received and the number of employees covered by these agreements.~~

~~(i) By June 30, 2004, and annually thereafter, the Administrative Director of the Division of Workers' Compensation shall prepare and notify members of the Legislature that a report authorized by this section is available upon request. The report based upon aggregate data shall include the following:~~

~~(1) Person hours and payroll covered by agreements filed.~~

~~(2) The number of claims filed.~~

~~(3) The average cost per claim shall be reported by cost components whenever practicable.~~

~~(4) The number of litigated claims, including the number of claims submitted to mediation, the appeals board, or the court of appeals.~~

~~(5) The number of contested claims resolved prior to arbitration.~~

~~(6) The projected incurred costs and actual costs of claims.~~

~~(7) Safety history.~~

~~(8) The number of workers participating in vocational rehabilitation.~~

~~(9) The number of workers participating in light-duty programs.~~

~~(10) Overall worker satisfaction.~~

~~The division shall have the authority to require those employers and groups of employers listed in subdivision (c) to provide the data listed above.~~

~~(j) The data obtained by the administrative director pursuant to this section shall be confidential and not subject to public disclosure under any law of this state. However, the Division of Workers' Compensation shall create derivative works pursuant to subdivisions (h) and (i) based on the collective bargaining agreements and data. Those derivative works shall not be confidential, but shall be public. On a monthly basis the administrative director shall make available an updated list of employers and unions entering into collective bargaining agreements containing provisions authorized by this section.~~

SEC. 12. Section 3201.7 of the Labor Code, as added by Chapter 866 of the Statutes of 2002, is repealed.

~~3201.7. (a) Except as provided in subdivisions (b) and (c), the Department of Industrial Relations and the courts of this state shall recognize as valid and binding any provision in a collective bargaining agreement between a private employer or groups of employers engaged in the aerospace or timber industries and a union that is the recognized or certified exclusive bargaining representative that establishes any of the following:~~

~~(1) An alternative dispute resolution system governing disputes between employees and employers or their insurers that supplements or replaces all or part of those dispute resolution processes contained in this division, including, but not limited to, mediation and arbitration. Any system of arbitration shall provide that the decision of the arbiter or board of arbitration is subject to review by the appeals board in the same manner as provided for reconsideration of a final order, decision, or award made and filled by a workers' compensation administrative law judge pursuant to the procedures set forth in Article 1 (commencing with Section 5900) of Chapter 7 of Part 4 of Division 4, and the court of appeal pursuant to the procedures set forth in Article 2 (commencing with Section 5950) of Chapter 7 of Part 4 of Division 4, governing orders, decisions, or awards of the appeals board. The findings of fact, award, order, or decision of the arbitrator shall have the same force and effect as an award, order, or decision of a workers' compensation administrative law judge. Any provision for~~

~~arbitration established pursuant to this section shall not be subject to Sections 5270, 5270.5, 5271, 5272, 5273, 5275, and 5277.~~

~~(2) The use of an agreed list of providers of medical treatment that may be the exclusive source of all medical treatment provided under this division.~~

~~(3) The use of an agreed, limited list of qualified medical evaluators and agreed medical evaluators that may be the exclusive source of qualified medical evaluators and agreed medical evaluators under this division.~~

~~(4) Joint labor management safety committees.~~

~~(5) A light-duty, modified job or return-to-work program.~~

~~(6) A vocational rehabilitation or retraining program utilizing an agreed list of providers of rehabilitation services that may be the exclusive source of providers of rehabilitation services under this division.~~

~~(b) Nothing in this section shall allow a collective bargaining agreement that diminishes the entitlement of an employee to compensation payments for total or partial disability, temporary disability, vocational rehabilitation, or medical treatment fully paid by the employer as otherwise provided in this division; nor shall any agreement authorized by this section deny to any employee the right to representation by counsel at all stages of the alternative dispute resolution process. The portion of any agreement that violates this subdivision shall be declared null and void.~~

~~(c) Subdivision (a) shall apply only to the following:~~

~~(1) An employer developing or projecting an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars ($250,000) or more, or any employer that paid an annual workers' compensation insurance premium, in California, of two hundred fifty thousand dollars ($250,000), in at least one of the previous three years.~~

~~(2) Groups of employers engaged in a workers' compensation safety group complying with Sections 11656.6 and 11656.7 of the Insurance Code, and established pursuant to a joint labor management safety committee or committees, which develops or projects annual workers' compensation insurance premiums of two million dollars ($2,000,000) or more.~~

~~(3) Employer or groups of employers that are self-insured in compliance with Section 3700 that would have projected annual~~

~~workers' compensation costs that meet the requirements of paragraph (1) in the case of employers, or paragraph (2) in the case of groups of employers.~~

~~(4) In the aerospace and timber industry, this section shall apply only to an affiliate of a national or international labor organization that has one or more affiliate local unions that negotiated an agreement or agreements pursuant to Section 3201.5 prior to January 1, 2003.~~

~~(d) Employers and labor representatives who meet the eligibility requirements of this section shall be issued a letter by the administrative director advising each employer and labor representative that, based upon the review of all documents and materials submitted as required by the administrative director, each has met the eligibility requirements of this section.~~

~~(e) The premium rate for a policy of insurance issued pursuant to this section shall not be subject to the requirements of Section 11732 or 11732.5 of the Insurance Code.~~

~~(f) No employer may establish or continue a program established under this section until it has provided the administrative director with all of the following:~~

~~(1) Upon its original application and whenever it is renegotiated thereafter, a copy of the collective bargaining agreement and the approximate number of employees who will be covered thereby.~~

~~(2) Upon its original application and annually thereafter, a valid and active license where that license is required by law as a condition of doing business in the state within the industries set forth in subdivision (a).~~

~~(3) Upon its original application and annually thereafter, a statement signed under penalty of perjury, that no action has been taken by any administrative agency or court of the United States to invalidate the collective bargaining agreement.~~

~~(4) The name, address, and telephone number of the contact person of the employer.~~

~~(5) Upon its original application, a plan agreed to between an employer and any affected union prior to the commencement of collective bargaining, that establishes a framework for the implementation of the system to be developed pursuant to paragraph (1) of subdivision (a).~~

~~(6) Any other information that the administrative director deems necessary to further the purposes of this section.~~

~~(g) No collective bargaining representative may establish or continue to participate in a program established under this section unless all of the following requirements are met:~~

~~(1) Upon its original application and annually thereafter, it has provided to the administrative director a copy of its most recent LM-2 or LM-3 filing with the United States Department of Labor, along with a statement, signed under penalty of perjury, that the document is a true and correct copy.~~

~~(2) It has provided to the administrative director the name, address, and telephone number of the contact person or persons of the collective bargaining representative or representatives.~~

~~(h) Commencing July 1, 2004, and annually thereafter, the Division of Workers' Compensation shall report to the Director of Industrial Relations the number of collective bargaining agreements received and the number of employees covered by these agreements.~~

~~(i) By June 30, 2004, and annually thereafter, the Administrative Director of the Division of Workers' Compensation shall prepare and notify members of the Legislature that a report authorized by this section is available upon request. The report based upon aggregate data shall include the following:~~

~~(1) Person hours and payroll covered by agreements filed.~~

~~(2) The number of claims filed.~~

~~(3) The average cost per claim shall be reported by cost components whenever practicable.~~

~~(4) The number of litigated claims, including the number of claims submitted to mediation, the appeals board, or the court of appeals.~~

~~(5) The number of contested claims resolved prior to arbitration.~~

~~(6) The projected incurred costs and actual costs of claims.~~

~~(7) Safety history.~~

~~(8) The number of workers participating in vocational rehabilitation.~~

~~(9) The number of workers participating in light-duty programs.~~

~~(10) Overall worker satisfaction.~~

~~The division shall have the authority to require those employers and groups of employers listed in subdivision (c) to provide the data listed above.~~

~~(j) The data obtained by the administrative director pursuant to this section shall be confidential and not subject to public disclosure under any law of this state. However, the Division of Workers' Compensation shall create derivative works pursuant to subdivisions (h) and (i) based on the collective bargaining agreements and data. Those derivative works shall not be confidential, but shall be public. On a monthly basis, the administrative director shall make available an updated list of employers and unions entering into collective bargaining agreements containing provisions authorized by this section.~~

SEC. 13. Section 3202 of the Labor Code is amended to read:

3202. This division and Division 5 (commencing with Section 6300) shall be liberally construed by the courts with the purpose of extending their benefits for the protection of persons injured in the course of their employment*, provided that the injury is both a "specific" injury as defined in Section 3208.1, and results in serious physical or bodily harm. This section shall apply only after it is determined that an injury in the course of employment has occurred*.

SEC. 14. Section 3208 of the Labor Code is amended to read:

3208. ''Injury'' includes any injury or disease arising out of the employment *that is certified by a physician using medical evidence based on objective medical findings,* including injuries to artificial members, dentures, hearing aids, eyeglasses, and medical braces of all types~~; provided, however that~~. *However,* eyeglasses and hearing aids ~~will~~ *shall* not be replaced, repaired, or otherwise compensated for, unless injury to them is incident to an injury causing disability.

SEC. 15. Section 3208.1 of the Labor Code is amended to read:

3208.1. *(a)* An injury may be either: ~~(a)~~ *(1)* ''specific,'' occurring as the result of one incident or exposure ~~which~~ *that* causes disability or need for medical treatment; or ~~(b)~~ *(2)* ''cumulative,'' occurring as repetitive mentally or physically traumatic activities extending over a period of time, the combined effect of which causes any disability or need for medical treatment.

The date of a cumulative injury shall be the date determined under Section 5412.

(b) In order to establish that a cumulative injury is compensable, an employee shall demonstrate by a preponderance of the evidence that the injury was substantially caused by actual activities of employment.

SEC. 16. Section 3208.3 of the Labor Code is amended to read:

3208.3. (a) ~~A psychiatric injury shall be compensable if it~~ *Notwithstanding any other provision of this division, no compensation may be paid for a psychiatric injury unless the employee demonstrates by clear and convincing evidence that all of the following conditions are met:*

(1) The injury is a mental disorder ~~which~~ *that* causes disability or need for medical treatment, and it is diagnosed pursuant to procedures promulgated under paragraph (4) of subdivision (j) of Section 139.2 or, until these procedures are promulgated, it is diagnosed using the terminology and criteria of the *most recent edition of the* American Psychiatric Association's Diagnostic and Statistical Manual of Mental Disorders~~, Third~~ *Fourth* Edition-Revised, or the terminology and diagnostic criteria of other psychiatric diagnostic manuals generally approved and accepted nationally by practitioners in the field of psychiatric medicine.

(2) The mental disorder arose out of and in the course of employment pursuant to Section 3600.

(3) The employment condition producing the mental disorder exists in a real and objective sense.

(4) Employment events that are sudden and extraordinary, not common to all fields of employment, and not generally inherent in the employee's regular and routine employment, are the predominant cause of the mental disorder. As used in this section, "sudden and extraordinary" employment event does not include a disciplinary, corrective, or job performance evaluation action by the employer, or a transfer, layoff, or cessation of employment.

(b) ~~(1) In order to establish that a psychiatric injury is compensable, an employee shall demonstrate by a preponderance of the evidence that actual events of employment were predominant as to all causes combined of the psychiatric injury.~~

~~(2) Notwithstanding paragraph (1), in the case of employees whose injuries resulted from being a victim of a violent act or from direct exposure to a significant violent act, the employee shall be required to demonstrate by a preponderance of the evidence that actual events of employment were a substantial cause of the injury.~~

~~(3) For the purposes of this section, "substantial cause" means at least 35 to 40 percent of the causation from all sources combined.~~

~~(c)~~ It is the intent of the Legislature in enacting this section to establish a new and higher threshold of compensability for psychiatric injury under this division.

~~(d)~~

(c) Notwithstanding any other provision of this division, no compensation shall be paid pursuant to this division for a psychiatric injury related to a claim against an employer unless the employee has been employed by that employer for at least six months. The six months of employment need not be continuous. This subdivision shall not apply if the psychiatric injury is caused by a sudden and extraordinary employment condition. Nothing in this subdivision shall be construed to authorize an employee, or his or her dependents, to bring an action at law or equity for damages against the employer for a psychiatric injury, where those rights would not exist pursuant to the exclusive remedy doctrine set forth in Section 3602 in the absence of the amendment of this section by the act adding this subdivision.

~~(e)~~

(d) Where the claim for compensation is filed after notice of termination of employment or layoff, including voluntary layoff, and the claim is for ~~an~~ *a psychiatric* injury occurring prior to the time of notice of termination or layoff, no compensation ~~shall~~ *may* be paid unless the employee demonstrates by a ~~preponderance of the~~ *clear and convincing* evidence that actual events of employment were predominant as to all causes combined of the psychiatric injury and one or more of the following conditions exist:

(1) Sudden and extraordinary events of employment were the cause of the injury.

(2) The employer has notice of the psychiatric injury under Chapter 2 (commencing with Section 5400) *of Part 4* prior to the notice of termination or layoff.

(3) The employee's medical records existing prior to notice of termination or layoff contain evidence of treatment of the psychiatric injury.

(4) ~~Upon~~ *There has been* a finding of sexual or racial harassment by any trier of fact, whether contractual, administrative, regulatory, or judicial.

(5) Evidence that the date of injury, as specified in Section 5411 or 5412, is subsequent to the date of the notice of termination or layoff, but prior to the effective date of the termination or layoff.

~~(f)~~

(e) For purposes of this section, an employee provided notice pursuant to Sections 44948.5, 44949, 44951, 44955, ~~44955.6,~~ *44955.5,* 72411, 87740, and 87743 of the Education Code shall be considered to have been provided a notice of termination or layoff only upon a district's final decision not to reemploy that person.

~~(g)~~

(f) A notice of termination or layoff that is not followed within 60 days by that termination or layoff shall not be subject to the provisions of this subdivision, and this subdivision shall not apply until receipt of a later notice of termination or layoff. The issuance of frequent notices of termination or layoff to an employee shall be considered a bad faith personnel action and shall make this subdivision inapplicable to the employee.

~~(h)~~

(g) No compensation under this division shall be paid by an employer for a psychiatric injury if the injury was substantially caused by a lawful, nondiscriminatory, good faith personnel action. The burden of proof shall rest with the party asserting the issue.

~~(i)~~

(h) When a psychiatric injury claim is filed against an employer, and an application for adjudication of claim is filed by an employer or employee, the division shall provide the employer with information concerning psychiatric injury prevention programs.

~~(j)~~

(i) An employee who is an inmate, as defined in subdivision (e) of Section 3351, or his or her family on behalf of an inmate, shall not be entitled to compensation for a psychiatric injury except as provided in subdivision (d) of Section 3370.

SEC. 17. Section 3600 of the Labor Code is amended to read:

3600. (a) Liability for the compensation provided by this division, in lieu of any other liability whatsoever to any person except as otherwise specifically provided in Sections 3602, 3706, and 4558, shall, without regard to negligence, exist against an employer for any injury sustained by his or her employees arising out of and in the course of the employment and for the death of any employee if the injury proximately causes death, in those cases where the following conditions of compensation concur:

(1) Where, at the time of the injury, both the employer and the employee are subject to the compensation provisions of this division.

(2) Where, at the time of the injury, the employee is performing service growing out of and incidental to his or her employment and is acting within the course of his or her employment.

(3) Where the ~~injury is proximately caused by the~~ employment *is the predominant cause of the injury, compared to all other causes combined*, either with or without negligence.

(4) Where the injury is not caused by the intoxication, by alcohol or the unlawful use of a controlled substance, of the injured employee. As used in this paragraph, ''controlled substance'' shall have the same meaning as prescribed in Section 11007 of the Health and Safety Code.

(5) Where the injury is not intentionally self-inflicted.

(6) Where the employee has not willfully and deliberately caused his or her own death.

(7) Where the injury does not arise out of an altercation in which the injured employee is the initial physical aggressor.

(8) Where the injury is not caused by the commission of a ~~felony, or a crime which is punishable as specified in subdivision (b) of Section 17 of the Penal Code,~~ *criminal act* by the injured employee, for which he or she has been convicted.

(9) Where the injury does not arise out of voluntary participation in any off-duty recreational, social, or athletic activity not constituting part of the employee's work-related duties, except where these activities are a reasonable expectancy of, or are expressly or impliedly required by, the employment. The administrative director shall promulgate reasonable rules and regulations requiring employers to post and keep posted in a conspicuous place or places a notice advising employees of the

provisions of this ~~subdivision~~ *paragraph*. Failure of the employer to post the notice shall not constitute an expression of intent to waive the provisions of this ~~subdivision~~ *paragraph.*

(10) Except for psychiatric injuries governed by subdivision (e) of Section 3208.3, where the claim for compensation is filed after notice of termination or layoff, including voluntary layoff, and the claim is for an injury occurring prior to the time of notice of termination or layoff, no compensation shall be paid unless the employee demonstrates by a preponderance of the evidence that one or more of the following conditions apply:

(A) The employer has notice of the injury, as provided under Chapter 2 (commencing with Section 5400) *of Part 4*, prior to the notice of termination or layoff.

(B) The employee's medical records, existing prior to the notice of termination or layoff, contain evidence of the injury.

(C) The date of injury, as specified in Section 5411, is subsequent to the date of the notice of termination or layoff, but prior to the effective date of the termination or layoff.

(D) The date of injury, as specified in Section 5412, is subsequent to the date of the notice of termination or layoff.

For purposes of this paragraph, an employee provided notice pursuant to Sections 44948.5, 44949, 44951, 44955, 44955.6, 72411, 87740, and 87743 of the Education Code shall be considered to have been provided a notice of termination or layoff only upon a district's final decision not to reemploy that person.

A notice of termination or layoff that is not followed within 60 days by that termination or layoff shall not be subject to the provisions of this paragraph, and this paragraph shall not apply until receipt of a later notice of termination or layoff. The issuance of frequent notices of termination or layoff to an employee shall be considered a bad faith personnel action and shall make this paragraph inapplicable to the employee.

(b) Where an employee, or his or her dependents, receives the compensation provided by this division and secures a judgment for, or settlement of, civil damages pursuant to those specific exemptions to the employee's exclusive remedy set forth in subdivision (b) of Section 3602 and Section 4558, the compensation paid under this division shall be credited against the judgment or settlement, and the employer shall be relieved from the obligation to pay further compensation to, or on behalf of, the

employee or his or her dependents up to the net amount of the judgment or settlement received by the employee or his or her heirs, or that portion of the judgment as has been satisfied.

SEC. 18. Section 3821 is added to the Labor Code, to read:

3821. Upon the request of an employer, an applicant for employment shall disclose both of the following:

(a) Whether he or she has ever been adjudicated to be in violation of Section 3820.

(b) Whether he or she has ever been convicted of violating Section 1871.4 of the Insurance Code or Section 550 of the Penal Code with respect to a workers' compensation insurance claim.

SEC. 19. Section 4062.7 is added to the Labor Code, to read:

4062.7. (a) On and after January 1, 2004, all evaluations and reports prepared by a physician with regard to the degree of permanent whole body impairment that an employee has sustained shall be based upon demonstrable medical evidence that indicates how the impairment restricts the function of the body or its members, organs, or psyche.

(b) For purposes of subdivision (a), the physician shall use established medical guidelines including the American Medical Association guides to the evaluation of permanent impairment, the American Psychiatric Associations' Diagnostic and Statistical Manual of Mental Disorders, the Manual for Orthopedic Surgeons in Evaluating Permanent Physical Impairment, and the Snellen Charts published by the American Medical Association Committee for Eye Injuries. Deviations from the guidelines contained in these publications shall not constitute a basis for excluding evidence from consideration, but shall be considered in determining the weight given to that evidence. Disability ratings shall not be based on all evaluations and reports that do not follow the established medical guidelines contained in these publications.

(c) This section shall apply to all evaluations and reports provided to the appeals board by an employee's treating physician or an independent medical examiner.

(d) Failure by a physician to comply with this section may result in the disapproval of the physician's fee for the evaluation or report.

SEC. 20. Section 4453.1 is added to the Labor Code, to read:

4453.1. Notwithstanding any other provision of law, for purposes of determining temporary disability benefits for any person entitled to benefits under this division as a result of an injury sustained by an inmate of any county jail, industrial farm, road camp, or city jail, or by an inmate assigned to a work release program under Section 4024.2 of the Penal Code, the average weekly earnings shall be taken at the minimum amount set forth in Section 4453 or the actual weekly wages lost due to disability resulting from the injury, whichever is less.

SEC. 21. Section 4600 of the Labor Code is amended to read:

4600. *(a)* Medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including orthotic and prosthetic devices and services, that is reasonably required to cure or relieve from the effects of the injury shall be provided by the employer. In the case of his or her neglect or refusal seasonably to do so, the employer is liable for the reasonable expense incurred by or on behalf of the employee in providing treatment. After ~~30~~ *120* days from the date the injury is reported, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area. However, if an employee has notified his or her employer in writing prior to the date of injury that he or she has a personal physician, the employee shall have the right to be treated by that physician from the date of injury. If an employee requests a change of physician pursuant to Section 4601, the request may be made at any time after the injury, and the alternative physician, chiropractor, or acupuncturist shall be provided within five days of the request as required by Section 4601. For the purpose of this section, ''personal physician'' means the employee's regular physician and surgeon, licensed pursuant to Chapter 5 (commencing with Section 2000) of Division 2 of the Business and Professions Code, who has previously directed the medical treatment of the employee, and who retains the employee's medical records, including his or her medical history.

~~Where~~

(b) Where at the request of the employer, the employer's insurer, the administrative director, the appeals board, or a workers' compensation *administrative law* judge, the employee submits to examination by a physician, he or she shall be entitled

to receive in addition to all other benefits herein provided all reasonable expenses of transportation, meals, and lodging incident to reporting for the examination, together with one day of temporary disability indemnity for each day of wages lost in submitting to the examination. Regardless of the date of injury, ''reasonable expenses of transportation'' includes mileage fees from the employee's home to the place of the examination and back at the rate of twenty-one cents ($0.21) a mile or the mileage rate adopted by the Director of the Department of Personnel Administration pursuant to Section 19820 of the Government Code, whichever is higher, plus any bridge tolls. The mileage and tolls shall be paid to the employee at the time he or she is given notification of the time and place of the examination.

~~Where~~

(c) Where, at the request of the employer, the employer's insurer, the administrative director, the appeals board, a workers' compensation *administrative law* judge, an employee submits to examination by a physician and the employee does not proficiently speak or understand the English language, he or she shall be entitled to the services of a qualified interpreter in accordance with conditions and a fee schedule prescribed by the administrative director. These services shall be provided by the employer. For purposes of this section, ''qualified interpreter'' means a language interpreter certified, or deemed certified, pursuant to Article 8 (commencing with Section 11435.05) of Chapter 4.5 of Part 1 of Division 3 of Title 2 of, or Section 68566 of, the Government Code.

(d) If the employee has not notified the employer that he or she has a personal physician, as specified in subdivision (a), then in the event of a disputed health care service, the employee may request an independent medical review pursuant to Article 5.55 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health and Safety Code.

SEC. 22. Section 4600.1 of the Labor Code is repealed.

~~4600.1. Any pharmacy providing medicines and medical supplies required by Section 4600 shall provide the generic drug equivalent, if a generic drug equivalent is available, unless the prescribing physician specifically provides otherwise in writing.~~

SEC. 23. Section 4600.1 is added to the Labor Code, to read:

4600.1. (a) Subject to subdivision (b), any person or entity that dispenses medicines and medical supplies, as required by Section 4600, shall dispense the generic drug equivalent.

(b) A person or entity shall not be required to dispense a generic drug equivalent under either of the following circumstances:

(1) When a generic drug equivalent is unavailable.

(2) When the prescribing physician specifically provides in writing that a nongeneric drug must be dispensed.

(c) For purposes of this section, "dispense" has the same meaning as the definition contained in Section 4024 of the Business and Professions Code.

(d) Nothing in this section shall be construed to preclude a prescribing physician, who is also the dispensing physician, from dispensing a generic drug equivalent.

SEC. 24. Section 4600.31 is added to the Labor Code, to read:

4600.31. (a) An employer may enter into a contract with a health care organization for the provision of health care services to injured employees that does not contain the time limitations imposed on employers specified in this article.

(b) In the event of a disputed health care service, the employee covered by a contract specified in subdivision (a) may request an independent medical review pursuant to Article 5.55 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health and Safety Code.

SEC. 25. Section 4600.37 is added to the Labor Code, to read:

4600.37. (a) Notwithstanding Section 4600, a self-insured employer, group of self-insured employers, or the insurer of an employer may contract with a preferred provider organization (PPO) for health care services required by this article to be provided to injured employees. Every employee shall have an opportunity to select a personal physician within the PPO network at any time. Every employee shall have the right to a second opinion from a participating provider on a matter pertaining to diagnosis or treatment from a participating physician.

(b) Each contract described in subdivision (a) shall provide all medical, surgical, chiropractic, acupuncture, and hospital treatment, including nursing, medicines, medical and surgical supplies, crutches, and apparatus, including artificial members, that is reasonably required to cure or relieve the effects of injury, as required by this division, without any payment by the employee

of deductibles, copayments, or any share of the premium. However, an employee may receive emergency medical treatment that is compensable from a medical service or health care provider that is not a member of the PPO.

(c) A self-insured employer, a group of self-insured employers, or the insurer of an employer that contracts with a preferred provider organization (PPO) for medical services shall give notice to each employee of eligible medical service providers, the employee's right to select any provider within the PPO network and to a second opinion from a physician within the PPO network as provided in subdivision (a), and any other information regarding the contract and the manner of receiving medical services.

(d) In the event the self-insured employer, group of self-insured employers, or the insurer of an employer no longer contracts with the PPO that has been treating the injured employee, the employee may continue treatment provided or arranged by the PPO. If the employee does not choose to continue treatment provided or arranged by the PPO, the employer may control the employee's treatment for 30 days from the date the injury was reported. After that period, the employee may be treated by a physician of his or her own choice or at a facility of his or her own choice within a reasonable geographic area.

(e) In the event of a disputed health care service, the employee covered by a contract specified in this section may request an independent medical review pursuant to Article 5.5 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health and Safety Code.

SEC. 26. Section 4603.2 of the Labor Code is amended to read:

4603.2. (a) *(1)* Upon selecting a physician pursuant to Section 4600, the employee or physician shall forthwith notify the employer of the name and address of the physician. ~~The~~

(2) The physician shall submit a report to the employer, within five working days from the date of ~~the initial examination and shall submit periodic reports at intervals that may be prescribed by rules and regulations adopted by the administrative director.~~

~~(b)~~ *any of the following:*

(A) The initial examination.

(B) Any significant changes in the employee's condition, treatment plan, or status.

(C) A claims administrator's reasonable request for additional information.

(3) The physician shall also submit a report within 21 days from the last report of any type during ongoing treatment.

(b) (1) Payment for medical treatment provided or authorized by the treating physician selected by the employee or designated by the employer shall be made by the employer within ~~60~~ *45 calendar* days after receipt of each separate, itemized billing, together with any required reports and any written authorization for services that may have been received by the physician. If the billing or a portion thereof is contested, denied, or considered incomplete, the physician shall be notified, in writing, that the billing is contested, denied, or considered incomplete *by the employer*, within 30 working days after receipt of the billing by the employer. A notice that a billing is incomplete shall state all additional information required to make a decision. Any properly documented amount not paid within the ~~60-day~~ *45 calendar day* period shall be increased by 10 percent, together with interest at the same rate as judgments in civil actions retroactive to the date of receipt of the bill, unless the employer does both of the following:

~~(1)~~

(A) Pays the uncontested amount within the ~~60-day~~ *45 calendar day* period.

~~(2)~~

(B) Advises, in the manner prescribed by the administrative director, the physician, or another provider of the items being contested, the reasons for contesting these items, and the remedies available to the physician or the other provider if he or she disagrees. In the case of a bill ~~which~~ *that* includes charges from a hospital, outpatient surgery center, or independent diagnostic facility, advice that a request has been made for an audit of the bill shall satisfy the requirements of this paragraph.

~~If~~

(2) If an employer contests all or part of a billing, any amount determined payable by the appeals board shall carry interest from the date the amount was due until it is paid.

~~An~~

(3) An employer's liability to a physician or another provider under this section for delayed payments shall not affect its liability to an employee under Section 5814 or any other provision of this division.

(c) Any interest or increase in compensation paid by an insurer pursuant to this section shall be treated in the same manner as an increase in compensation under subdivision (d) of Section 4650 for the purposes of any classification of risks and premium rates~~,~~ and any system of merit rating approved or issued pursuant to Article 2 (commencing with Section 11730) of Chapter 3 of Part 3 of Division 2 of the Insurance Code.

(d) (1) Whenever an employer or insurer employs an individual or contracts with an entity to conduct a review of a billing submitted by a physician or medical provider, the employer or insurer shall make available to that individual or entity all documentation submitted together with that billing by the physician or medical provider. When an individual or entity conducting a bill review determines that additional information or documentation is necessary to review the billing, the individual or entity shall contact the claims administrator or insurer to obtain the necessary information or documentation that was submitted by the physician or medical provider pursuant to subdivision (b).

(2) An individual or entity reviewing a bill submitted by a physician or medical provider shall not alter the procedure codes billed or recommend reduction of the amount of the bill unless the documentation submitted by the physician or medical provider with the bill has been reviewed by that individual or entity. If the reviewer does not recommend payment as billed by the physician or medical provider, the explanation of review shall provide the physician or medical provider with a specific explanation as to why the reviewer altered the procedure code or amount billed and the specific deficiency in the billing or documentation that caused the reviewer to conclude that the altered procedure code or amount recommended for payment more accurately represents the service performed.

(3) Unless the physician or medical provider has billed for extraordinary circumstances related to the unusual nature of the medical services rendered pursuant to subdivision (b) of Section 5307.1, this subdivision shall not apply when a bill submitted by a physician or medical provider is reduced to the amount or

amounts specified in the ~~Official Medical Fee Schedule~~ *official medical fee schedule*, preferred provider contract, or negotiated rate for the procedure codes billed.

(4) The appeals board shall have jurisdiction over disputes arising out of this subdivision pursuant to Section 5304.

(e) When the employer contests, denies, or seeks review of the billing, the employer shall only be required to pay any interest or increase in compensation for delayed payment pursuant to subdivision (b), if the provider of medical services objects in writing to the employer's written explanation for contesting, denying, or seeking review of the billing within 45 calendar days of receipt of payment, notice of nonpayment, or explanation of review. The failure of the provider to object within this 45 calendar day period shall preclude the provider from seeking further reimbursement or filing a lien.

(f) The total payment to the provider of medical services shall not exceed the maximum reasonable fee listed in the official medical fee schedule.

SEC. 27. Section 4635.15 is added to the Labor Code, to read:

4635.15. Notwithstanding any other provision of law, an employer is not required to offer vocational rehabilitation services. However, once an employer has elected to offer vocational rehabilitation services the employer shall comply with all requirements pertaining to the provision of vocational rehabilitation services.

SEC. 28. Section 4637 of the Labor Code is amended to read:

4637. (a) Within 10 days after the employee is medically eligible under subdivision (c) of Section 4636, or the employer receives a physician's report, or knowledge of a physician's opinion, indicating an employee is medically eligible, ~~the~~ *an employer who has elected to offer vocational rehabilitation services pursuant to Section 4635.15* shall notify the employee of his or her medical eligibility for vocational rehabilitation services. The notice shall be in writing, in the form and manner prescribed by the administrative director, with a copy forwarded to the vocational rehabilitation ~~unit.~~ *unit.* The notice shall include all of the following:

(1) An explanation of vocational rehabilitation services available to the employee, including the maintenance allowance

payable under Section 139.5 and the effect of any delay in the acceptance of vocational rehabilitation services.

(2) Instructions as to how the employee may apply for vocational rehabilitation services.

(3) Notice that failure to apply within 90 days of receipt of notice of medical eligibility may terminate the employee's entitlement to vocational rehabilitation services, unless the treating physician determines that the employee is medically unable to participate in the provision of vocational rehabilitation services except as otherwise provided by Section 5410.

(4) Notice of the employee's right to an agreed upon qualified rehabilitation representative and to request an evaluation of vocational feasibility prior to any acceptance or rejection of vocational rehabilitation services and the right to request a change of qualified rehabilitation representative pursuant to Section 4640.

(5) Notice that vocational rehabilitation services may not be settled or otherwise converted to cash payments.

Immediately thereafter, unless the employee's medical condition precludes participation or the employee declines to accept vocational rehabilitation services, the employer shall assign a qualified rehabilitation representative, selected in agreement with the employee, to determine if the employee meets the vocational feasibility requirements of paragraph (2) of subdivision (a) of Section 4635. If agreement cannot be reached, a qualified rehabilitation representative shall be selected pursuant to Section 4640.

(b) If an employee is notified of his or her potential entitlement to vocational rehabilitation services pursuant to subdivision (a) and it is subsequently determined that the employee is not a qualified injured worker, the employer shall notify the employee, in the form and manner prescribed by the administrative director, that he or she is not entitled to further vocational rehabilitation services, the reasons therefor, and the procedure to be followed in contesting the determination.

SEC. 29. Section 4639 of the Labor Code is amended to read:

4639. (a) If ~~the~~ *an* employer *that elects to offer vocational rehabilitation services pursuant to Section 4635.15* fails to assign a qualified rehabilitation representative as required by Section 4636, fails to notify the employee of possible entitlement to these services pursuant to Section 4637, or fails to provide timely

vocational rehabilitation services, the employee may request the administrative director to authorize the provision of vocational rehabilitation services at the expense of the employer. The administrative director shall immediately advise the employer of the receipt of the request.

(b) If the employer, within 20 days of receipt of the administrative director's notification, fails either to agree to provide vocational rehabilitation services or to demonstrate that the employee is not a qualified injured worker, the administrative director shall authorize the provision of vocational rehabilitation services through a qualified rehabilitation representative of the employee's choice or, at the employee's request, through an independent vocational evaluator.

SEC. 30. Section 4642 of the Labor Code is amended to read:

4642. (a) If ~~the~~ *an* employer *that has elected to offer vocational rehabilitation services pursuant to Section 4635.15* fails to assign a qualified rehabilitation representative or to commence vocational rehabilitation service in a timely manner as required by Section 4637, or otherwise causes any delay in the provision of vocational rehabilitation services, the full maintenance allowance shall be paid in its entirety by the employer, including the amount payable under paragraph (2) of subdivision (d) of Section 139.5, for the period of the delay. The maintenance allowance and any costs attributable to the delay shall not be subject to the overall cap on vocational rehabilitation services provided for by Section 139.5.

(b) If the failure to meet the requirements of subdivision (a) is primarily the result of actions by the insurer, any increase in the costs that result shall be charged against the insurer's expenses.

SEC. 31. Section 4646 of the Labor Code is amended to read:

4646. ~~(a)~~ Settlement or commutation of prospective vocational rehabilitation services shall not be permitted under Chapter 2 (commencing with Section 5000) or Chapter 3 (commencing with Section 5100) of Part 3 except ~~as set forth in subdivision (b), or~~ upon a finding by a workers' compensation judge that there are good faith issues that, if resolved against the employee, would defeat the employee's right to all compensation under this division.

~~(b) The employer and a represented employee may agree to settle the employee's right to prospective vocational rehabilitation~~

~~services with a one-time payment to the employee not to exceed ten thousand dollars ($10,000) for the employee's use in self-directed vocational rehabilitation. The settlement agreement shall be submitted to, and approved by, the administrative director's vocational rehabilitation unit upon a finding that the employee has knowingly and voluntarily agreed to relinquish his or her rehabilitation rights. The rehabilitation unit may only disapprove the settlement agreement upon a finding that receipt of rehabilitation services is necessary to return the employee to suitable gainful employment.~~

~~(c) Prior to entering into any settlement agreement pursuant to this section, the attorney for a represented employee shall fully disclose and explain to the employee the nature and quality of the rights and privileges being waived.~~

SEC. 32. Section 5307.1 of the Labor Code is amended to read:

5307.1. (a) (1) The administrative director, after public hearings, shall adopt and revise, no less frequently than biennially, an official medical fee schedule ~~which~~ *that* shall establish reasonable maximum fees paid for medical services provided pursuant to this division. ~~No later than January 1, 1995, the administrative director shall have revised the schedule. By no later than January 1, 1995, the~~ *All medical services provided to a worker from the date of injury shall be subject to the official medical fee schedule, regardless of the date the injury is accepted as, or determined to be, compensable. The official medical fee* schedule shall include ~~services~~ *all of the following:*

(A) Services for health care facilities licensed pursuant to ~~Section 1250~~ *Chapter 2 (commencing with Section 1250) of Division 2* of the Health and Safety Code, and drugs and pharmacy services. The fee schedule for health care facilities shall take into consideration cost and service differentials for various types of facilities.

~~(2) The administrative director shall include services~~

(B) On or before January 1, 2005, services for outpatient surgery facilities and emergency room facilities, as well as pharmacy services and products, durable medical equipment, ambulance services, and home health care services.

(C) Services provided by physical therapists, physician assistants, and nurse practitioners ~~in the official fee schedule~~

~~adopted and revised pursuant to paragraph (1)~~. Nothing in this ~~paragraph~~ *subparagraph* shall affect the ability of physicians to continue to be reimbursed for their services in accordance with the official medical fee schedule adopted pursuant to *this* paragraph ~~(1)~~ for the provision of services within their scope of practice.

(2) Where applicable, when revising the official medical fee schedule as required by paragraph (1) or to include additional services as required by this section, the administrative director shall base the fee on the Medicare resource-based relative value scale (RBRVS) multiplied by 1.0. The administrative director shall review the fee schedule on an annual basis and may modify the multiplier if required to meet one or more specified access-to-physician standards, as developed by the administrative director.

(3) The administrative director shall consult with statewide professional organizations representing affected providers on the update of the official medical fee schedule.

~~(b) Nothing in this section shall prohibit a medical provider or a licensed health care facility from being paid by an employer or carrier fees in excess of those set forth on~~ *Prior to the adoption of any update of* the official medical fee schedule, ~~provided that the fee is:~~

~~(1) Reasonable.~~

~~(2)~~ *the administrative director shall consult with the Industrial Medical Council. The council shall hold a public hearing no less than 45 days before the date of the proposed adoption of the update to give interested parties the opportunity for comment. The council shall make recommendations regarding the proposed update, and the administrative director shall include those recommendations in the rulemaking file.*

(b) (1) The total payment to the provider of medical services shall not exceed the maximum reasonable fee listed in the official medical fee schedule.

(2) Notwithstanding paragraph (1), nothing in this section shall prohibit a medical provider or a licensed health care facility from being paid fees by an employer or carrier that are in excess of those set forth on the official medical fee schedule, if the fee is both of the following:

(A) Reasonable, as specified in paragraph (4).

(B) Accompanied by itemization and justified by an explanation of extraordinary circumstances related to the unusual nature of the medical services rendered.

In no event shall a physician charge in excess of his or her usual fee.

(3) In the event a service is not set forth on the official medical fee schedule, nothing in this section shall prohibit a medical provider or licensed health care facility from being paid a fee by an employer or carrier if the fee is reasonable, as specified in paragraph (4).

(4) In determining the reasonableness of a fee, for purposes of paragraphs (2) and (3), the appeals board may consider a number of factors, including, but not limited to, the following:

(A) The usual fee of the medical provider or licensed health care facility.

(B) The usual fee of other medical providers or licensed health care facilities located in the same geographical area.

(C) The usual fee accepted by the medical provider or licensed health care facility as opposed to the usual fee charged.

(D) The amount accepted by the medical provider or licensed health care facility from Medicare for the same service.

(E) Any other relevant factors.

(c) In the event of a dispute between the physician and the employer or carrier concerning the medical fees charged, the physician may be allowed a reasonable fee for testimony, if a physician testifies pursuant to the employer's or carrier's subpoena, and the ~~referee~~ *workers' compensation administrative law judge* determines that the medical fee charged was reasonable.

(d) Except as provided in Section 4626, the official medical fee schedule shall not apply to medical-legal expenses, as defined ~~by~~ *in* Section 4620.

SEC. 33. Section 5307.21 of the Labor Code, as added by Chapter 6 of the Statutes of 2002, is repealed.

~~5307.21. (a) The administrative director shall have the sole authority to develop an outpatient surgery facility fee schedule for services not performed under contract, provided that the schedule meets all of the following requirements:~~

~~(1) The schedule shall include all facility charges for outpatient surgeries performed in any facility authorized by law to perform the surgeries. The schedule may not include the fee of any~~

~~physician and surgeon providing services in connection with the surgery.~~

~~(2) The schedule shall promote payment predictability, minimize administrative costs, and ensure access to outpatient surgery services by insured workers.~~

~~(3) The schedule shall be sufficient to cover the costs of each surgical procedure, as well as access to quality care.~~

~~(4) The schedule shall include specific provisions for review and revision of related fees no less frequently then biennially.~~

~~(5) The schedule shall be adopted after public hearings pursuant to Section 5307.3 and shall be included within the official medical fee schedule.~~

~~(b) The process used by the administrative director to develop an outpatient surgery fee schedule shall contain the following elements:~~

~~(1) A formal analysis of one year of published data collected pursuant to Section 128737 of the Health and Safety Code, with the assistance of an independent consultant with demonstrated expertise in outpatient surgery service.~~

~~(2) Any published data collected from providers of outpatient surgery services.~~

~~(3) Payment data including, but not limited to, type of payer and amount charged.~~

~~(4) Cost data including, but not limited to, actual expenses for labor, supplies, equipment, implants, anesthesia, overhead, and administration.~~

~~(5) Outcome data including, but not limited to, expected level of rehabilitation, expected coverage timeframe, and incidence of infection.~~

~~(6) Access data including, but not limited to, date of injury, date of surgery recommendation, and data of procedure.~~

~~(7) Other data that is mutually agreed to by the Office of Statewide Health Planning and Development and the administrative director. The administrative director shall consult with the Office of Statewide Health Planning and Development to ensure that the data collected is comprehensive and relevant to the development of a fee schedule.~~

~~(c) The outpatient surgery facility fee schedule shall reflect input from workers' compensation insurance carriers, businesses,~~

~~organized labor, providers of outpatient surgical services, and patients receiving outpatient surgical services.~~

SEC. 34. Section 5307.21 of the Labor Code, as added by Chapter 866 of the Statutes of 2002, is repealed.

~~5307.21. (a) The administrative director shall have the sole authority to develop an outpatient surgery facility fee schedule for services not performed under contract, provided that the schedule meets all of the following requirements:~~

~~(1) The schedule shall include all facility charges for outpatient surgeries performed in any facility authorized by law to perform the surgeries. The schedule may not include the fee of any physician and surgeon providing services in connection with the surgery.~~

~~(2) The schedule shall promote payment predictability, minimize administrative costs, and ensure access to outpatient surgery services by injured workers.~~

~~(3) The schedule shall be sufficient to cover the costs of each surgical procedure, as well as access to quality care.~~

~~(4) The schedule shall include specific provisions for review and revision of related fees no less frequently than biennially.~~

~~(5) The schedule shall be adopted after public hearings pursuant to Section 5307.3 and shall be included within the official medical fee schedule.~~

~~(b) The process used by the administrative director to develop an outpatient surgery fee schedule shall contain the following elements:~~

~~(1) A formal analysis of one year of published data collected pursuant to Section 128737 of the Health and Safety Code, with the assistance of an independent consultant with demonstrated expertise in outpatient surgery service.~~

~~(2) Any published data collected from providers of outpatient surgery services.~~

~~(3) Payment data including, but not limited to, type of payer and amount charged.~~

~~(4) Cost data including, but not limited to, actual expenses for labor, supplies, equipment, implants, anesthesia, overhead, and administration.~~

~~(5) Outcome data including, but not limited to, expected level of rehabilitation, expected coverage timeframe, and incidence of infection.~~

~~(6) Access data including, but not limited to, date of injury, date of surgery recommendation, and date of procedure.~~

~~(7) Other data that is mutually agreed to by the Office of Statewide Health Planning and Development and the administrative director. The administrative director shall consult with the Office of Statewide Health Planning and Development to ensure that the data collected is comprehensive and relevant to the development of a fee schedule.~~

~~(c) The outpatient surgery facility fee schedule shall reflect input from workers' compensation insurance carriers, businesses, organized labor, providers of outpatient surgical services, and patients receiving outpatient surgical services.~~

~~(d) At least 90 days prior to commencing the public hearings related to an outpatient surgery fee schedule as prescribed by Section 5307.3, the administrative director shall provide the Assembly Committee on Insurance and the Senate Committee on Labor and Industrial Relations a comprehensive report on the data analysis required by this section and the administrative director's recommendations for an outpatient surgery fee schedule.~~

SEC. 35. Section 5307.27 is added to the Labor Code, to read:

5307.27. (a) The administrative director, after public hearings, shall adopt, not later than July 1, 2004, and revise, no less frequently than biennially, an official utilization schedule, based on the guidelines and protocols developed pursuant to Section 139.15.

(b) In the event of a disputed health care service in connection with the utilization schedule, an employee may request an independent medical review pursuant to Article 5.55 (commencing with Section 1374.30) of Chapter 2.2 of Division 2 of the Health and Safety Code.

SEC. 36. Section 5410 of the Labor Code is amended to read:

5410. Nothing in this chapter shall bar the right of any injured worker to institute proceedings for the collection of compensation, including vocational rehabilitation services *if his or her employer has elected to offer these services pursuant to Section 4635.15*, within five years after the date of the injury upon the ground that the original injury has caused new and further disability or that the provision of vocational rehabilitation services has become feasible because the employee's medical condition has improved or because of other factors not capable of determination at the time

the employer's liability for vocational rehabilitation services otherwise terminated. The jurisdiction of the appeals board in these cases shall be a continuing jurisdiction within this period. This section does not extend the limitation provided in Section 5407.

SEC. 37. Section 5502 of the Labor Code is amended to read:

5502. (a) Except as provided in subdivisions (b) and (d), the hearing shall be held not less than 10 days, and not more than 60 days, after the date a declaration of readiness to proceed, on a form prescribed by the court administrator, is filed. If a claim form has been filed for an injury occurring on or after January 1, 1990, and before January 1, 1994, an application for adjudication shall accompany the declaration of readiness to proceed.

(b) The court administrator shall establish a priority calendar for issues requiring an expedited hearing and decision. A hearing shall be held and a determination as to the rights of the parties shall be made and filed within 30 days after the declaration of readiness to proceed is filed if the issues in dispute are any of the following:

(1) The employee's entitlement to medical treatment pursuant to Section 4600.

(2) The employee's entitlement to, or the amount of, temporary disability indemnity payments.

(3) The employee's entitlement to vocational rehabilitation services, or the termination of an employer's liability to provide these services to an employee *if the employer has elected to offer vocational rehabilitation services pursuant to Section 4635.15*.

(4) The employee's entitlement to compensation from one or more responsible employers when two or more employers dispute liability as among themselves.

(5) Any other issues requiring an expedited hearing and determination as prescribed in rules and regulations of the administrative director.

(c) The court administrator shall establish a priority conference calendar for cases in which the employee is represented by an attorney and the issues in dispute are employment or injury arising out of employment or in the course of employment. The conference shall be conducted by a workers' compensation administrative law judge within 30 days after the declaration of readiness to proceed. If the dispute cannot be resolved at the conference, a trial shall be set as expeditiously as possible, unless

good cause is shown why discovery is not complete, in which case status conferences shall be held at regular intervals. The case shall be set for trial when discovery is complete, or when the workers' compensation administrative law judge determines that the parties have had sufficient time in which to complete reasonable discovery. A determination as to the rights of the parties shall be made and filed within 30 days after the trial.

(d) The court administrator shall report quarterly to the Governor and to the Legislature concerning the frequency and types of issues which are not heard and decided within the period prescribed in this section and the reasons therefor.

(e) (1) In all cases, a mandatory settlement conference shall be conducted not less than 10 days, and not more than 30 days, after the filing of a declaration of readiness to proceed. If the dispute is not resolved, the regular hearing shall be held within 75 days after the declaration of readiness to proceed is filed.

(2) The settlement conference shall be conducted by a workers' compensation administrative law judge or by a referee who is eligible to be a workers' compensation administrative law judge or eligible to be an arbitrator under Section 5270.5. At the mandatory settlement conference, the referee or workers' compensation administrative law judge shall have the authority to resolve the dispute, including the authority to approve a compromise and release or issue a stipulated finding and award, and if the dispute cannot be resolved, to frame the issues and stipulations for trial. The appeals board shall adopt any regulations needed to implement this subdivision. The presiding workers' compensation administrative law judge shall supervise settlement conference referees in the performance of their judicial functions under this subdivision.

(3) If the claim is not resolved at the mandatory settlement conference, the parties shall file a pretrial conference statement noting the specific issues in dispute, each party's proposed permanent disability rating, and listing the exhibits, and disclosing witnesses. Discovery shall close on the date of the mandatory settlement conference. Evidence not disclosed or obtained thereafter shall not be admissible unless the proponent of the evidence can demonstrate that it was not available or could not have been discovered by the exercise of due diligence prior to the settlement conference.

(f) In cases involving the Director of the Department of Industrial Relations in his or her capacity as administrator of the Uninsured Employers Fund, this section shall not apply unless proof of service, as specified in paragraph (1) of subdivision (d) of Section 3716 has been filed with the appeals board and provided to the Director of Industrial Relations, valid jurisdiction has been established over the employer, and the fund has been joined.

(g) Except as provided in subdivision (a) and in Section 4065, the provisions of this section shall apply irrespective of the date of injury.

SEC. 38. Section 5705.1 is added to the Labor Code, to read:

5705.1. (a) The burden of proof for the apportionment regarding permanent disability under Sections 4663, 4750, and 4750.5 shall rest upon the defendant. In accordance with Section 3202.5, the defendant shall demonstrate by a preponderance of the evidence, and by reasonable medical probability, that absent the industrial injury, the injured worker had lost, as a consequence of a preexisting injury or illness, some capacity to perform the activity affected by the injury.

(b) Notwithstanding any other provision of this code relating to workers' compensation benefits, including Section 4062.9, in denying apportionment the appeals board may not, in determining permanent disability, rely on any medical report that fails to fully address the issue of apportionment and fails to set forth the basis of the medical opinion. In denying apportionment, the appeals board may not rely on any medical report that fails to apportion a previous injury or illness that has been the subject of a prior claim for damages or that fails to provide a discussion of the medical processes by which a previously asserted injury or illness resolved without affecting bodily function.

(c) If the applicant has received a prior award of permanent disability, it shall be conclusively presumed that the prior permanent disability exists at the time of any subsequent industrial injury.

(d) The accumulation of all permanent disability awards issued to one individual employee shall not exceed 100 percent unless the employee's injury or illness is conclusively presumed to be total in character pursuant to Section 4662.

(e) Permanent disability or death benefits shall not be payable unless the industrial injury is the predominant cause of the disability or death when compared to all causes of injury in total.

SEC. 39. Section 5814 of the Labor Code is repealed.

~~5814. When payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the full amount of the order, decision, or award shall be increased by 10 percent. Multiple increases shall not be awarded for repeated delays in making a series of payments due for the same type or specie of benefit unless there has been a legally significant event between the delay and the subsequent delay in payments of the same type or specie of benefits. The question of delay and the reasonableness of the cause therefor shall be determined by the appeals board in accordance with the facts. This delay or refusal shall constitute good cause under Section 5803 to rescind, alter, or amend the order, decision, or award for the purpose of making the increase provided for herein.~~

SEC. 40. Section 5814 is added to the Labor Code, to read:

5814. (a) When payment of compensation has been unreasonably delayed or refused, either prior to or subsequent to the issuance of an award, the amount of the payment unreasonably delayed or refused may be increased up to 25 percent or up to five hundred dollars ($500), whichever is greater. In proceeding under this section, the appeals board shall use its discretion to accomplish a fair balance and substantial justice between the parties.

(b) As a precondition to a claim for penalties under this section, the employee shall give written notice to the employer of the claimed unreasonable delay or refusal of payment of compensation. If, within 20 days from the date of services of this notice, the employer pays a self-imposed increase of 10 percent of the amount of payment delayed or refused, in addition to any other self-imposed increases due under this division, there shall be no further penalty allowed under this section. If the employer disputes whether the delay or refusal is unreasonable, and the workers' compensation administrative law judge determines that the delay or refusal violates this section, the workers' compensation administrative law judge shall award the penalty prescribed in subdivision (a). In determining whether the delay or refusal is unreasonable, the workers' compensation administrative law

judge shall consider only the specific facts resulting in the delay or refusal of the specific payment that is the subject of the request for penalties.

(c) The appeals board shall have no jurisdiction to hear a claim for penalties under subdivision (a), unless the employee files a claim for a penalty within one year from the date of the alleged unreasonable delay or refusal to pay benefits. Upon the approval of a compromise and release by the appeals board, it shall be conclusively presumed that any existing or potential penalties have been resolved, unless expressly excluded by the terms of the compromise and release.

(d) When a penalty is awarded under subdivision (a), the appeals board may allow a credit for any self-imposed increase under subdivision (d) of Section 4650 or subdivision (b), in order to accomplish a fair balance and substantial justice between the parties.

(e) Nothing in this section shall be construed to create a civil cause of action.

SEC. 41. Section 5814.5 of the Labor Code is repealed.

~~5814.5. When the payment of compensation has been unreasonably delayed or refused subsequent to the issuance of an award by an employer that has secured the payment of compensation pursuant to Section 3700, the appeals board shall, in addition to increasing the order, decision, or award pursuant to Section 5814, award reasonable attorneys' fees incurred in enforcing the payment of compensation awarded.~~

SEC. 42. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.

~~read:~~

~~139.3. (a) Notwithstanding any other provision of law, to the extent those services are paid pursuant to Division 4 (commencing with Section 3200), it is unlawful for a physician to refer a person for outpatient surgery, clinical laboratory, diagnostic nuclear~~

~~medicine, radiation oncology, physical therapy, physical rehabilitation, psychometric testing, home infusion therapy, or diagnostic imaging goods or services whether for treatment or medical-legal purposes if the physician or his or her immediate family has a financial interest with the person or in the entity that receives the referral.~~

~~(b) For purposes of this section and Section 139.31, the following shall apply:~~

~~(1) ''Diagnostic imaging'' includes, but is not limited to, all X-ray, computed axial tomography magnetic resonance imaging, nuclear medicine, positron emission tomography, mammography, and ultrasound goods and services.~~

~~(2) ''Immediate family'' includes the spouse and children of the physician, the parents of the physician, and the spouses of the children of the physician.~~

~~(3) ''Physician'' means a physician as defined in Section 3209.3.~~

~~(4) A ''financial interest'' includes, but is not limited to, any type of ownership, interest, debt, loan, lease, compensation, remuneration, discount, rebate, refund, dividend, distribution, subsidy, or other form of direct or indirect payment, whether in money or otherwise, between a licensee and a person or entity to whom the physician refers a person for a good or service specified in subdivision (a). A financial interest also exists if there is an indirect relationship between a physician and the referral recipient, including, but not limited to, an arrangement whereby a physician has an ownership interest in any entity that leases property to the referral recipient. Any financial interest transferred by a physician to, or otherwise established in, any person or entity for the purpose of avoiding the prohibition of this section shall be deemed a financial interest of the physician.~~

~~(5) A ''physician's office'' is either of the following:~~

~~(A) An office of a physician in solo practice.~~

~~(B) An office in which the services or goods are personally provided by the physician or by employees in that office, or personally by independent contractors in that office, in accordance with other provisions of law. Employees and independent contractors shall be licensed or certified when that licensure or certification is required by law.~~

~~(6) The "office of a group practice" is an office or offices in which two or more physicians are legally organized as a partnership, professional corporation, or not-for-profit corporation licensed according to subdivision (a) of Section 1204 of the Health and Safety Code for which all of the following are applicable:~~

~~(A) Each physician who is a member of the group provides substantially the full range of services that the physician routinely provides, including medical care, consultation, diagnosis, or treatment, through the joint use of shared office space, facilities, equipment, and personnel.~~

~~(B) Substantially all of the services of the physicians who are members of the group are provided through the group and are billed in the name of the group and amounts so received are treated as receipts of the group, and except that in the case of multispecialty clinics, as defined in subdivision (*l*) of Section 1206 of the Health and Safety Code, physician services are billed in the name of the multispecialty clinic and amounts so received are treated as receipts of the multispecialty clinic.~~

~~(C) The overhead expenses of, and the income from, the practice are distributed in accordance with methods previously determined by members of the group.~~

~~(c) (1) It is unlawful for a licensee to enter into an arrangement or scheme, such as a cross-referral arrangement, that the licensee knows, or should know, has a principal purpose of ensuring referrals by the licensee to a particular entity that, if the licensee directly made referrals to that entity, would be in violation of this section.~~

~~(2) It shall be unlawful for a physician to offer, deliver, receive, or accept any rebate, refund, commission, preference, patronage dividend, discount, or other consideration, whether in the form of money or otherwise, as compensation or inducement for a referred evaluation or consultation.~~

~~(d) No claim for payment shall be presented by an entity to any individual, third-party payer, or other entity for a good or service furnished pursuant to a referral prohibited under this section.~~

~~(e) A physician who refers to, or seeks consultation from, an organization in which the physician has a financial interest shall disclose this interest to the patient or if the patient is a minor, to the~~

~~patient's parents or legal guardian in writing at the time of the referral.~~

~~(f) No insurer, self-insurer, or other payor shall pay a charge or lien for any good or service resulting from a referral in violation of this section.~~

~~(g) A violation of subdivision (a) shall be a misdemeanor. The appropriate licensing board shall review the facts and circumstances of any conviction pursuant to subdivision (a) and take appropriate disciplinary action if the licensee has committed unprofessional conduct. Violations of this section may also be subject to civil penalties of up to five thousand dollars ($5,000) for each offense, which may be enforced by the Insurance Commissioner, Attorney General, or a district attorney. A violation of subdivision (c), (d), (e), or (f) is a public offense and is punishable upon conviction by a fine not exceeding fifteen thousand dollars ($15,000) for each violation and appropriate disciplinary action, including revocation of professional licensure, by the Medical Board of California or other appropriate governmental agency.~~

~~SEC. 2. No reimbursement is required by this act pursuant to Section 6 of Article XIII B of the California Constitution because the only costs that may be incurred by a local agency or school district will be incurred because this act creates a new crime or infraction, eliminates a crime or infraction, or changes the penalty for a crime or infraction, within the meaning of Section 17556 of the Government Code, or changes the definition of a crime within the meaning of Section 6 of Article XIII B of the California Constitution.~~

O